The Law Commission

Consultation Paper No. 128

Mentally Incapacitated Adults and Decision-Making

A New Jurisdiction

HMSO

The Law Commission was set up by section 1 of the Law Commissions Act 1965 for the purpose of promoting the reform of the law.

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This consultation paper was completed on 23 December 1992, when the Honourable Mr Justice Peter Gibson was Chairman. It is circulated for comment and criticism only and does not represent the final views of the Law Commission.

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It may be helpful for the Law Commission, either in discussion with others concerned or in any subsequent recommendations, to be able to refer to and attribute comments submitted in response to this consultation paper. Whilst any request to treat all, or part, of a response in confidence will, of course, be respected, if no such request is made the Law Commission will assume that the response is not intended to be confidential.

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THE LAW COMMISSION

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MENTALLY INCAPACITATED ADULTS AND DECISION-MAKING

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PART I

INTRODUCTION

1.1 In April 1991 the Law Commission published a preliminary Consultation Paper, Mentally Incapacitated Adults and Decision-Making : An Overview.[1] Its object was to assess the extent of the need for reform and the most practicable way forward in a difficult and diffuse area. To date over 120 responses have been received. We have also held valuable meetings with several groups of interested organisations and individuals. In September 1991 the Scottish Law Commission also published a Discussion Paper on Mentally Disabled Adults.[2] The main criticisms of the present law in Scotland reflect concerns very similar to those identified in England and Wales.[3] We are now embarking on a second round of consultation in which we shall canvass more precise and detailed provisional proposals for reform.

1.2 Our initial consultations have convinced us that there is a need for some reform. The following main messages have emerged:

(i) There is much concern, particularly among carers and service-providers, about the gaps and uncertainties in the present law.

(ii) The most obvious deficiencies relate to the lack of any effective machinery in public law for protecting incapacitated or vulnerable people from abuse and neglect, or in private law for resolving disputes between individuals about their care, or generally for

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1 Mentally Incapacitated Adults and Decision-Making: An Overview (1991), Consultation Paper No. 119.

2 Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances (1991), Discussion Paper No. 94.

3 A number of options for reform are proposed by the Scottish Law Commission, including the creation of a statutory "personal guardian" empowered to take personal welfare decisions on behalf of a disabled person and a new statutory system of financial management.

legitimating and regulating the substitute decision-making which in practice regularly takes place.

(iii) There is much support for an overall rather than a piecemeal approach to reform, but some fear that this would take too long to construct and implement.

(iv) There is a general view that any new procedures must be quick, cheap, flexible, accessible and easy to use, whilst providing effective safeguards for the person concerned.

1.3 We have decided that the best way of taking the project forward is by a series of separate consultations on particular topics, the results of which could either be combined into a single overall framework or implemented separately. Those topics can be roughly characterised as (1) the "private" law, (2) the public law, and (3) the medical law. As was stated in our preliminary consultation paper,[4] it is not our intention to re-open discussion upon the compulsory admission and treatment provisions in the Mental Health Act 1983. The Secretary of State for Health recently announced in the House of Commons that her Department would be reviewing the Mental Health Act 1983, giving consideration to whether new legal powers are needed to ensure that mentally ill people in the community get the care they need, and whether the present legal powers are being used as effectively as they can.[5] The announcement came after a recommendation from the Royal College of Psychiatrists that the 1983 Act should be amended to incorporate a "community supervision order", intended to ensure that patients in the community continue to take their treatment.[6] Such matters are outside the scope of this paper.

1.4 The most striking gap in the present law is the lack of any general "private law" jurisdiction which can be invoked when disputes or uncertainties arise in relation to residence and other matters of personal care and welfare. Many other countries have private law

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[4] Consultation Paper No.119, para. 1.17.

[5] Mrs. Virginia Bottomley, Written Answer, *Hansard*, 13 January 1993, vol. 216, col. 731.

[6] *Community Supervision Orders*, A Report of the Royal College of Psychiatrists (January 1993). The Report is for consultation and does not represent the final views of the Royal College.

jurisdictions which seek to solve these problems by providing for the appointment of a "guardian" (in common law jurisdictions) or "tutor" (in civil law systems).[7] A "guardianship" scheme does exist in England and Wales under the Mental Health Act 1983,[8] but this "operates as a social services function and a form of state intervention,"[9] rather than to meet the problems and concerns of family and carers.

1.5 In relation to financial matters, on the other hand, there are a number of existing legal procedures which can authorise substitute decision-making, usually by family or carers or other private individuals. The jurisdiction of the Court of Protection is extremely wide, although some of our respondents thought it cumbersome and costly. Financial decisions can also be delegated in advance of incapacity by the use of an enduring power of attorney. Another scheme enables the Secretary of State for Social Security to make an "appointment" of a substitute to collect benefits. These procedures have all been subject to criticism. Many respondents also saw the division of "financial" decision-making from other personal decisions as unrealistic and unworkable.

1.6 This paper therefore explores the idea of a new legal machinery whereby substitute decisions, whether "financial" or "personal" or both, could be authorised at an appropriate level. This would fill the gap in the existing law in relation to personal matters and rationalise its procedures in relation to financial matters. For the purposes of discussion we have put forward a number of proposals for change but, of course, these are entirely provisional and we would welcome all comments, criticisms and alternative suggestions.

1.7 The specific policy issues which arise in relation to "public" rather than "private" intervention will lead to separate consultations on the subject of public authority powers in this field. In these we will consider the powers which should be available to the health and social services authorities to intervene in an emergency to protect vulnerable people from

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7 Consultation Paper No.119, Part V on "The Experience Abroad".

8 For a detailed discussion of the scheme see *ibid.*, paras. 3.24 - 3.34.

9 *Ibid.*, para. 3.31.

abuse and neglect, together with the longer term intervention which is currently provided by guardianship under the Mental Health Act 1983.

1.8 In relation to medical matters, the House of Lords in *Re F* [10] considered for the first time the lawfulness of providing medical treatment to an adult who is incapable of giving consent. A procedure was developed to deal with the most controversial cases, such as the sterilisation of mentally handicapped women, and the law has developed in response to other situations.[11] This specialised body of case law and the particular problems raised in relation to medical treatment will also require detailed consideration, and we shall be dealing separately with the whole topic of medical decision-making.

1.9 The policy aims set out in the consultation paper were supported by many respondents and remain the basis of our approach:

(i) that people are enabled and encouraged to take for themselves those decisions which they are able to take;

(ii) that where it is necessary in their own interests or for the protection of others that someone else should take decisions on their behalf, the intervention should be as limited as possible and concerned to achieve what the person himself would have wanted; and

(iii) that proper safeguards be provided against exploitation, neglect, and physical, sexual or psychological abuse.[12]

1.10 It is implicit in the aim of "limited" intervention that any substitute decisions be taken at the lowest appropriate level and with the least possible procedural formality. Our responses revealed very little support for any system requiring every mentally incapacitated adult to be in some way identified, labelled and provided with a continuing substitute decision-maker.

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[10] [1990] 2 A.C. 1.

[11] *Re T* [1992] 3 W.L.R. 782; *Re AB*, *The Times*, 10 December 1992 (C.A.).

[12] Consultation Paper No. 119, para. 4.27.

Many decisions can and should be taken by carers without formal appointment or approval. Others should be taken by or in consultation with administrative bodies. Some will always have to be taken by a judicial body operating a judicial procedure. The aim is that the decision be taken at the lowest level which is consistent with the protection of the client both from the improper usurpation of his or her autonomy and from improper decision-making.

1.11 The rest of this paper is arranged as follows. In Part II, we deal with the problems of family and carers in deciding what they can and cannot do for a mentally disabled relative or person in their care and raise the question of whether the law should grant them explicit but limited authority to take certain decisions. In Part III, we discuss the people to whom any new or redesigned private law jurisdiction should apply. At present such people are termed "patients" but this is a misleading term in relation to people living in the community and requiring no particular medical or psychiatric care. We therefore propose to use the term "client" in this paper but would welcome any alternative suggestions. In Part IV, we consider the general balance to be struck between administrative and judicial authorities and the principles upon which they should operate. In Part V, we discuss the existing machinery for financial decision-making and how it might be strengthened and integrated with any new machinery for personal decision-making. In Part VI, we discuss a possible new jurisdiction for personal decision-making. Finally, in Part VII, we deal with the mechanisms available for the person concerned to decide in advance how or by whom his or her financial or personal affairs should be managed in the event of any later incapacity.

PART II

THE POSITION OF FAMILY AND CARERS

Introduction

2.1 At present many decisions, especially in the "personal care" field, are efficiently and ethically made by carers without any formal authority. Unfortunately some decisions which abuse or exploit the incapacitated person will also be made in this way. If informal arrangements fail or prove inadequate the only recourse is to the Court of Protection (for financial matters) or the High Court declaratory jurisdiction (for personal care matters). In this Part, we discuss whether certain "informal" arrangements should be given statutory recognition, with the grant of a legitimating authority to carers and guidance as to how it should be exercised.

The present law

2.2 It was apparent from our responses that many carers are concerned about the lack of any clear authority to carry out the ordinary tasks of looking after an incapacitated person, not knowing what they can do and, conversely, what they cannot. The consultation paper listed the variety of decisions which have to be made, ranging from simple daily decisions about eating, dressing and hygiene through to major decisions about where to live or whether to have irreversible medical treatment.[1] Restrictions on the lawfulness of such decisions may be found in the criminal law or in the tort of trespass to the person.

2.3 The situation of carers was analysed at some length by Lord Goff in the House of Lords in the case of *Re F.*[2] This concerned a proposed sterilisation operation but Lord Goff extended his discussion to those carrying out non-medical care of the mentally incompetent.

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[1] Consultation Paper No. 119, para. 1.10.

[2] [1990] 2 A.C. 1.

He began with the "fundamental principle, now long established, that every person's body is inviolate." Consent (usually) renders physical interference lawful and another recognised exception lies in "physical contact which is generally acceptable in the ordinary conduct of everyday life."[3] Although it had been suggested in the Court of Appeal that general care and mundane medical treatment fell within the latter exception, Lord Goff instead identified "the principle of necessity" as the justification for treatment without consent. From the case-law,[4] he derived the basic requirements that:

> "not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person."[5]

Lord Goff explicitly related this doctrine to the day-to-day care of an assisted person, as meaning that "the relative or friend or neighbour who comes in to look after him, will commit no wrong when he or she touches his body."[6] These comments are strictly obiter, and the scope of any such common law doctrine remains uncertain. Our consultations demonstrated that it is certainly not well known or understood. There is a good argument for introducing a clear statutory replacement for any existing common law justifications in so far as they apply to carers.

2.4 The extent of informal substitute decision-making about financial matters is unclear. In many cases the carer will not be able to gain control of the incapacitated person's finances without formal authority from the Court of Protection. However, banks and fund managers may be able to release funds to carers on the basis of contractual authority, even where no enduring power of attorney or receivership order has been made, and movable chattels are

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[3] As set out in *Collins v. Wilcock* [1984] 1 W.L.R. 1172.

[4] Principally, but not exclusively, that concerned with the agency of necessity of ship-masters. There are also cases concerned with the preservation of life, the protection of the mentally disordered and the duty to bury the dead.

[5] [1990] 2 A.C. 1, 75.

[6] [1990] 2 A.C. 1, 76.

often easily sold without formal authority. A person who has been able, without any documentary authority, to obtain possession of property belonging to an incapacitated person will often be able to deal with it (sell items and spend money) subject only to obligations under the criminal law and the torts of trespass to goods and conversion.

2.5 The tort of trespass to goods is founded on any act of physical interference with another's possession of property. The tort of conversion is founded on an act of interference which deprives the owner of the use or possession of any property. An act amounting to a claim for exclusive possession (e.g. sale) by one co-owner will be an act of conversion.[7] Consent is, of course, a defence to any action. Where the owner is incapable of consenting the defence of necessity may be available if, in an emergency for example, interference is reasonably necessary to protect the property.[8] It will not apply in other circumstances, even where the person interfering has acted in good faith. In contrast to any "personal care" decision, such financial decisions can be placed before the Court of Protection. It can, however, be argued that the Court of Protection procedures are costly, intimidating to non-lawyers and unnecessary in many situations. There may be scope for allowing some limited financial steps to be taken without formal procedural steps or at least for increasing those which can be taken administratively rather than judicially.[9]

Decision-makers from a statutory list of relatives

2.6 It has been suggested that members of an incapacitated person's family might be "appointed" from a statutory list to take substitute decisions, even if they are not the carers of the person. Their decisions would not have to be limited to those taken "to care for" the incapacitated person. Spouses,[10] children, parents and siblings are obvious candidates for inclusion on such a list.

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7 Torts (Interference with Goods) Act 1977, s.10(1)(a).

8 See dicta in *Kirk v. Gregory* (1876) 1 Ex.D. 55., and *Rigby v. Chief Constable of Northants* [1985] 1 W.L.R. 1242 at 1254.

9 See Part V.

10 Including cohabitants who are treated as spouses for the purpose of the Mental Health Act 1983.

2.7 One argument in favour of a statutory list is that many receivers and attorneys *are* closely related to those they act for. The use of a list would avoid court involvement where the rights of the incapacitated person can be protected without it. Many incapable people receive services of some sort, so that abuse or neglect by a "family manager" is likely to be noticed and referred to an appropriate authority. Moreover, if a system of "personal care" powers of attorney is available,[11] then it will be possible for some people to opt out of any statutory list system.

2.8 There are, however, strong arguments against such a system. Many people choose to live separately from their families and might greatly object to a family member being authorised by statute to exercise choice on their behalf. If there has been estrangement, the person authorised may be more likely to abuse the authority given. However carefully any list of family members attempted to reflect the range of life choices made in contemporary society, it might be inevitable that those with unconventional family structures would suffer.[12] It can be argued that a system of statutory "family management" is simply a version of "extended minority" for disabled people (or "repeated minority" for those with senile dementia). This concept was said to be outdated and offensive by the great majority of our respondents.

2.9 We tend to think the difficulties of constructing a principled system of statutory "family management" outweigh its likely benefits. Close family members who are unhappy with the decisions being taken by others would have access to any new jurisdiction to deal with disputes about personal as well as financial matters. Consequently we provisionally propose that:

1. There should be no statutory authority to take decisions for an incapacitated person simply on the basis of a family relationship.

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[11] See Part VII.

[12] As, for example, where the closest bond of a young adult is with a former foster-carer.

A statutory authority for carers

2.10 We see a much stronger case for clarifying in statute the authority which informal carers have in relation to the people they are looking after. This will not only reassure them of the legality of the actions and decisions they currently take, but also encourage them to act where it is reasonable to do so. At the same time, the limits of that authority, and the circumstances in which resort to an administrative or judicial body is required, could be spelled out. Section 3(5) of the Children Act 1989 offers a useful model for such an enabling provision:

> "A person who -
> (a) does not have parental responsibility for a particular child; but
> (b) has care of the child,
> may (subject to the provisions of this Act) do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare."

The object of this provision is not to confer any new power upon carers but to clarify the power and indeed the responsibility that they already have.

2.11 A "child", however, is easily defined[13] and identifiable, in cases of doubt, by means of a birth certificate. There is no guidance to be found in *Re F* on how to define or identify "incapable" people (there being no issue as to the incapacity of the disabled person in that case). Lord Goff's test as formulated refers to the impracticality of communicating with the person to be assisted. We are not aware of any similar statutory authority in other jurisdictions to which we could turn for guidance.[14] In principle, any statutory authority should be limited to those who fall within whatever definition of incapacity is adopted for any

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[13] Children Act 1989, s.195(1) "'child' means...a person under the age of eighteen."

[14] Although as the availability of guardianship is invariably restricted, there must be reliance on some other authority, even without the benefit of Lord Goff's dicta in *Re F*.

new jurisdiction.[15] However, we appreciate that carers who wish to rely on the authority may not have the necessary medical (if mental disorder is required) and other assessment skills to establish incapacity. In borderline cases this could be a difficulty. On the other hand, where a person of questionable capacity is being properly cared for without objecting, the carer may rely either on implied consent if the person concerned is capable or on the statutory authority if not. We invite views on whether the carer should only be required to have reasonable grounds for believing that the person is incapacitated.

2.12 We see less difficulty in defining the carers who are to be empowered with the authority, and favour the simplest possible formulation of "a person who has care of..."[16] This would apply to professional and family or neighbourhood carers. The difference in status may result in a different standard of what is reasonable, since training and professional standards may go to reasonableness.

2.13 The test formulated by Lord Goff requires a necessity to act. However, in relation to permanently incapable people, he acknowledged that "necessity" was very wide and included whatever was in their best interests and was reasonable to do. We think reference to "necessity" might be unduly restrictive. It is questionable whether anyone "needs" to have a bath or "needs" to have their money spent for them. Since the purpose of this authority would be to enable carers to care, we think a reference to reasonable actions preferable. We therefore provisionally propose that:

> **2. Anyone who has care of an incapacitated person [or who has reasonable grounds for believing a person in his or her care to be incapacitated] may do what is reasonable in all the circumstances to care for that person and to safeguard and promote his or her personal welfare.**

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[15] See Part III below.

[16] Compare the existing provision in the Mental Health Act 1983, s.127(2), imposing criminal liability on an individual who ill-treats or wilfully neglects "a mentally disordered patient...in his custody or care (whether by virtue of any legal or moral obligation or otherwise)."

A "best interests" criterion

2.14 The test formulated by Lord Goff requires that the substitute decision-maker act "in the best interests of" the incapacitated person. As the consultation paper explained, the best interests test is often presented in opposition to the substituted judgment test.[17] The latter was preferred by many of our respondents, though it was conceded that it was hard to apply to persons who had never had been able to form judgments of their own. We doubt that the two tests need be mutually exclusive, and favour a compromise whereby a best interests test is modified by a requirement that the substitute decision-maker first goes through an exercise in substituted judgment.[18]

2.15 We think a bland reference to a "best interests" criterion insufficient and would propose that at least some statutory guidance be given. The carer should be directed to consider the wishes of the person. The principle that the "least restrictive option" should always be preferred should be included.[19] It may even be desirable to remind any carer that (in accordance with the principle of the least restrictive option) the incapacitated person should always be encouraged to take any decision which he or she is able to take. We therefore provisionally propose that the carer's authority should be modified by the following:

3. In the exercise of this authority, a carer must act in the best interests of an incapacitated person, taking into account:

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

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[17] Consultation Paper No. 119, paras. 4.22 and 4.23.

[18] Foreign statutes invoke the principles in varying amounts of detail, in order to control and direct the nature of the substitute decision-making they permit. In Alberta a guardian must exercise his powers (1) in the person's best interests (2) to encourage capacity and (3) in the least restrictive manner possible. Under the Ontario draft legislation a lengthy list of some thirteen duties for any guardian or attorney is set out. In Victoria any guardian is under one duty to act in the person's best interests, with a non-exhaustive list of definitions then appended.

[19] See further Consultation Paper No.119, para. 4.20.

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

Limits to a carer's authority

2.16 The most obvious limits on the authority of carers are their potential liabilities in the law of tort or under the criminal law.[20] Further, since we are also proposing a jurisdiction which can solve problems and disputes by making a tailor-made order, a person (including the incapacitated person) aggrieved or concerned about informal steps being taken by a carer will have a remedy. However, there is also a need to protect incapacitated people from certain particularly bad decisions which they do not have the capacity to challenge.

2.17 It may well be that particular exclusions and limitations on the carer's authority are necessary in relation to medical treatment and we shall be considering this elsewhere. In relation to personal care, we propose a general restriction against the use of confinement or restraint in the absence of judicial authority. By confinement we mean physical methods of keeping a person in one place.[21] This is an area of increasing concern to social work professionals, especially in relation to the care of elderly dementia sufferers.[22] Recent

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[20] See paras. 2.20-2.22 below.

[21] This may be necessary to ensure that the legislation complies with the European Convention on Human Rights, in relation to detention. Article 5 of the Convention states that "everyone has the right to liberty and security of the person." Article 5(4) requires a speedy determination if people are to be deprived of their liberty. Article 6 provides for "fair and public" hearings to determine civil rights. It does appear possible that the grant of an authority to interfere with such rights without an independent finding of "unsoundness of mind" would offend against the Convention.

[22] Methods used in residential homes have been said to include straps on chairs, locks and bolts on doors and electronic monitoring, as well as more subtle tactics such as the strategic placement of furniture and the arrangements for keeping clothing. See further, Counsel and Care, *What If They Hurt*

legislation drafted in Ontario includes a duty on guardians and attorneys not to restrain the incapacitated person.[23] It may be argued that guidance as to "minimum restriction" is included in the best interests criteria set out above.[24] However, a specific statutory direction can give an important indication of ethos and principle. In our view there are some methods of confinement which ought not to be used without independent authorisation unless they are essential to protect the person concerned or other people from serious harm. It is however difficult to identify the precise boundary between automatically unacceptable and potentially reasonable methods. For example, elderly dementia sufferers may be deprived of outdoor clothing or kept in an environment which is so warm as to make them continually drowsy. Drugs may be administered which have a sedating effect. The exit may be difficult to reach and the door hard to open. It is not envisaged that such "management" techniques would constitute "confinement" although questions may be raised about whether in the circumstances it was reasonable to care for a particular incapacitated person in this way. However, it would surely constitute confinement (whether or not reasonable) to prevent a persistent "wanderer" from attempting to leave by locking him or her in a room. Restraint by tethering an incapacitated person to a bed, chair or toilet pipe would not only be confinement but may also constitute an offence.[25] We therefore provisionally propose that:

4. It is not reasonable for a carer to confine an incapacitated person unless such action is essential to prevent an immediate risk of serious harm to that person or others.

2.18 Apart from that one area, we doubt whether there are any types of personal care decision that should automatically be taken out of the ambit of the carer's authority. Although a case could be made for excluding a change of residence, which is undoubtedly an extremely serious decision with implications for the long-term health and welfare of the person

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Themselves? (1992).

[23] Substitute Decisions Bill, clause 63 (7) - a duty not to "...use confinement or monitoring devices or restrain the person physically or by means of drugs... unless the practice is essential to prevent serious bodily harm to the person or to others, or allows the person greater freedom or enjoyment."

[24] See para. 2.15 above.

[25] See below, para. 2.22.

concerned, there are many circumstances in which such a change is inevitable. It also requires the co-operation of others, which brings with it a certain amount of protection. To insist upon a formal sanction in every case would undoubtedly be a burdensome innovation. Our preferred approach is to focus on the issue of coercion. We do not think it right that carers should be permitted, without independent authorisation, to use physical force to oblige an incapacitated person to act in accordance with a decision to which that person positively objects. A carer might want the person to move to a residential home, or to prevent him or her seeing someone whom the carer believed to be exploiting the person whether sexually or financially; if, however, the person objected to the carer's decision then further steps ought to be taken. We acknowledge that this could place carers in a dilemma. Where an incapacitated person's behaviour is particularly difficult the carer at present has an unenviable choice between using (possibly unlawfully) physical methods of coercion, doing nothing, and asking that person to leave. In practice this course may be more difficult for family members than for proprietors of residential homes. We nevertheless believe that coercion is not justified without independent authorisation, and later in this paper we will propose a mechanism whereby application can be made to a judicial body for an order dealing with a specific issue, such as whether the incapacitated person should have to move to a new residence or cease having contact with certain people.[26] We therefore provisionally propose that:

5. It is not reasonable for a carer to force an incapacitated person to act in accordance with a decision to which the incapacitated person objects, unless such action is essential to prevent an immediate risk of serious harm to that person or others.

2.19 The discussion above has been limited to decisions about personal care and welfare. However, it would be possible to include some decisions about the spending of money or the disposition of chattels. In practice, many such decisions will be made by carers at present. There may be a greater risk of abuse and exploitation in the financial field than in personal care, but there are also limitations on the transactions that a carer could carry out because of

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[26] See below, paras. 6.8 - 6.12.

the requirements of third parties. There is also a greater array of statutory provisions giving some scope for administrative action. We therefore propose to consider this question further in Part V.

The carer's liabilities

2.20 Although there is no duty at common law for anyone to take over care of another person, there is a common law duty of care on anyone who does take on the care of a "helpless or infirm" person.[27] Hence, there can be civil liability in the tort of negligence for loss or damage resulting from breach of the duty. Civil liability may also lie in the tort of trespass to the person (subject to the defences of necessity or, if our proposal were to be adopted, of statutory authority). If a duty is imposed by statute, the tort of breach of statutory duty may be pleaded by plaintiffs as an alternative or in preference to the tort of negligence. Unless the matter is made clear, the courts have then to establish whether the legislature intended the statute to confer a right of action on the individual in such circumstances.

2.21 We think that the ordinary law of tort is capable of providing adequate protection for the incapacitated person as it stands. If, however, a statutory authority with associated duties to exercise it in accordance with the person's best interests (and ascertainable wishes and feelings) were to be enacted, it might be desirable to clarify whether or not there was a right of action for breach of those duties. This might be thought unduly burdensome for carers unless there were some protection, perhaps along similar lines to that currently available for action taken in pursuance of the Mental Health Act 1983. This gives exemption from liability in civil[28] proceedings in respect of such action "unless the act was done in bad faith or without reasonable care".[29] Further, the leave of the High Court is required before civil

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[27] M.A. Millner, *Negligence in Modern Law*, p.33 n.1.

[28] A similar exemption also extends to criminal proceedings, although proceedings for an offence under the Mental Health Act itself (which the Act provides can only be instituted by or with the consent of the Director of Public Prosecutions) are excluded: Mental Health Act 1983, s.139(3).

[29] *Ibid.*, s.139(1).

proceedings can be brought.[30] These provisions apply only where the compulsory procedures of the 1983 Act are concerned.[31] A procedural hurdle of this nature would in our view be entirely unjustifiable in relation to carers where no formal steps have been taken, but we do suggest that a carer's liability for exceeding or breaching the proposed statutory authority should be limited to acts done in bad faith or without reasonable care. Hence we provisionally propose that:

6. A carer who acts in pursuance of the proposed statutory authority should only be liable if he or she does so in bad faith or without reasonable care.

2.22 The general criminal law applies to carers who assault those they care for. In addition, there can be criminal liability for the breach of a duty to care for a helpless or infirm person.[32] Various statutory provisions also impose criminal liability for sexual acts with certain persons, on the basis of their status as mentally impaired.[33] Additionally, statute makes it a specific criminal offence for an individual "to ill-treat or wilfully to neglect a mentally disordered patient who is for the time being...in his custody or care (whether by virtue of any legal or moral obligation or otherwise)."[34] Whilst there may be grounds for reviewing the exact formulation of this offence, pending such review we would see value in what would be, in practice, a very modest extension of the offence to include all incapacitated persons.[35] We provisionally propose that:

7. The offence in section 127(2) of the Mental Health Act 1983 should be extended to protect all incapacitated persons from ill-treatment or wilful neglect by their carers.

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30 *Ibid.*, s.139(2). Criminal proceedings must be brought by or with the consent of the Director of Public Prosecutions.

31 In *R.* v. *Moonsami Runighian* [1977] Crim.L.R. 361, it was held that the equivalent section of the Mental Health Act 1959 did not apply to the treatment of an informal patient.

32 *R v. Stone*, *R v. Dobinson*, [1977] Q.B. 354 where a conviction for manslaughter relied on the reckless breach of the duty to care for the victim.

33 For a fuller discussion of the various statutory provisions see Consultation Paper No. 119, para. 2.27.

34 Mental Health Act 1983, s.127 (2).

35 See below, Part III. We provisionally propose the definition of incapacity should include a condition of mental disorder except in cases of inability to communicate.

PART III

DEFINING THE CLIENT GROUP

Introduction

3.1 Legal incapacity can arise from a variety of conditions and may apply in situations ranging from voting in an election to making a legally binding contract disposing of a valuable asset. The common law often applies a test requiring that a person must understand in broad terms the nature and likely effect of what he or she is doing.[1] In cases involving the management of a person's financial affairs the test for capacity has been limited by the requirement that the person concerned must not only be "incapable of managing his property and affairs" but be so incapable by reason of mental disorder.[2]

3.2 As the consultation paper stressed, capacity is a legal concept rather than a medical one. Of various approaches, it was said that the function approach, looking at the way the decision-maker confronts a particular decision, was most widely supported by informed commentators (and already often applied by the common law).[3] A large majority of our respondents supported the function approach but stated that existing tests were neither clear nor widely understood. It was urged that any new test should cater for cases of partial or fluctuating capacity. Whilst a function test seems to be widely favoured, the details of such a test could vary considerably.

3.3 In this part we consider the following issues in relation to the people who should be covered by any new or redesigned jurisdiction: (1) whether it should be exclusive from or overlap with the courts' statutory and inherent powers in relation to children; (2) whether a

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[1] This is the test applied in relation to contracts and marriage. Additional criteria apply in relation to making a will. For a full discussion of the various common law tests see Consultation Paper No. 119, paras. 2.13 - 2.35.

[2] Mental Health Act 1983, s.94(2).

[3] Consultation Paper No. 119, para. 2.44.

requirement of "mental disorder" should be a pre-condition in every case; (3) how incapacity itself should be defined; (4) whether any other people should be specifically included; and (5) the standard of proof.

The relevant age

3.4 Although the Court of Protection has jurisdiction to deal with the property and affairs of a minor it rarely exercises that jurisdiction.[4] It was an important aspect of the Children Act 1989 that disabled children were brought firmly into the general law relating to children. However, whilst a "child" for its purposes is a person under 18,[5] no care or supervision order can be made in relation to a child of 17 (or 16, if married); public protective intervention is therefore unavailable to those aged 17 (or 16, if married). In the private law field, orders can only be made or continued once a child has reached 16 if there are "exceptional" circumstances (which would clearly include incapacity).[6]

3.5 The principle of normalisation would suggest that an incapacitated person should be placed in the same position as any other person of the same age. It would satisfy both this principle and the philosophy of the Children Act to leave private disputes about the administration of property or the care or welfare of incapable minors to be resolved under the Children Act scheme, and make any new jurisdiction available only to those aged 18 and over. This, however, would leave an undesirable one (or two, if married) year gap during which public intervention to protect an incapacitated minor would only be available under the surviving inherent jurisdiction. One solution is to differentiate between the ages for public and private intervention under the new jurisdiction. The other is to have one age, namely 16, as the qualifying age for the new jurisdiction but accept some overlap between it and child law. The difficulty with this is the existing parental responsibility (and the courts' powers) to make

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[4] The Master has stated that the court is only "able to accept jurisdiction" if satisfied "that the mental disability will continue after the child reaches 18." Mrs. Macfarlane, Master of the Court of Protection, and Stephen Jakobi, "Court of Protection", (1991) 33 L.S.Gaz. 15-16.

[5] Children Act 1989, s.105(1).

[6] *Ibid.*, s.9(6) and (7).

at least some decisions on behalf of at least some children up to the age of 18.[7] Can it then be acceptable to have two jurisdictions applicable in the same case which may employ different definitions of capacity, different procedures, and different principles of intervention? An alternative solution would be to allow public law intervention under the Children Act 1989 in respect of incapacitated children.

3.6 We tend to think that any overlap will not produce difficulties in practice. Further, if there were a properly defined jurisdiction for decision-making on behalf of mentally incapacitated adults, it might be more appropriate in principle for 16 and 17 year olds to be considered under that jurisidiction rather than as if they were young children. Hence we provisionally propose that:

1. The new jurisdiction should extend to persons aged 16 and over.

The requirement of "mental disorder"

3.7 Establishing "mental disorder" is a prerequisite to the exercise of the Court of Protection's powers under Part VII of the Mental Health Act 1983 and the court requires a medical certificate in support of each application.[8] "Mental disorder" is defined in the Mental Health Act 1983 as meaning "mental illness, arrested or incomplete development of mind, psychopathic disorder *and any other disorder or disability of mind.*"[9]

3.8 The Court of Protection when exercising its supervisory powers under the Enduring Powers of Attorney Act 1985, requires no evidence (except in contested cases) in support of the attorney's belief that the donor is or may be becoming mentally incapable by reason of

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7 *Re W* [1992] 3 W.L.R. 758.

8 Mental Health Act 1983, s.94(2). The Court may however take steps in an emergency to protect the property of a person who may only later be decided to be incapable, and then only pending the decision as to incapacity: see *ibid.*, s.98. A blank certificate with accompanying guidance is provided by the Court and must be signed by the certificating doctor who need have no specialist knowledge of mental disorder: See Form CP3 and the Court of Protection Rules 1984, r.32 (evidence from one doctor is sufficient).

9 Section 1(2), emphasis added. See B. Hoggett, *Mental Health Law* (3rd ed. 1990) ch. 2 for a full discussion of the definition.

mental disorder. Procedures for establishing the inability to act of a claimant under the Social Security (Claims and Payments) Regulations 1987[10] are even less stringent. Where claimants are "unable for the time being to act" for themselves the Department of Social Security may appoint a suitable person to receive benefits on their behalf.[11] Although the regulations do not specify the type of incapacity required both the leaflets supplied to prospective appointees and the Income Support Manual indicate that claimants should be mentally incapacitated before an appointment is made. Guidance in the Income Support Manual refers to claimants being unable to act because "they do not have the mental ability to understand and control their own affairs e.g. because of senility or mental illness". The decision as to whether or not an appointee is necessary is made by a civil servant on behalf of the Secretary of State and no medical evidence is required.

3.9 As stated above, the common law test of capacity is not explicitly concerned with any diagnosis of "mental disorder". We now consider arguments both for and against including a requirement that mental disorder (as defined by the Mental Health Act 1983 or otherwise) be part of a uniform test for mental incapacity in the areas under discussion.

Arguments against

3.10 One argument against including mental disorder is the risk that an assumption of incapacity will automatically follow from a finding that the person concerned is suffering from mental disorder. The requirement might also distract attention from and undermine the importance of any subsequent function test. One of our respondents argued that "mental disorder" - a medical tag - is simply superfluous to the legal and moral issues at stake in this field. There is concern that because some people perceive mental disorder as being akin to "mad" or "dangerous" behaviour it stigmatises those to whom the label is attached. It is also argued that any diagnostic precondition disentitles those people who have no discernible

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[10] Social Security (Claims and Payments) Regulations 1987 S.I.1987, No.1968, reg. 33.

[11] There can be no appointment to act on behalf of a claimant if a receiver has been appointed by the Court of Protection or a curator, tutor, factor or guardian has been appointed by a court in Scotland. The Income Support Manual [7/90] para. 2.1004 further suggests that no appointee action will be necessary where there is an authorised "Power of Attorney" arrangement, and the person holding the authorisation is suitable.

handicap or medical condition but are nevertheless in need of care, services or protection with respect to their personal welfare, property and finances. Also the requirement could exclude cases where the person has, for whatever reason, a total inability to communicate which is or may be unconnected to any mental disorder. Lastly, it might be argued that the legal definition of mental disorder (in the Mental Health Act 1983) is itself outmoded and problematic, requiring doctors to diagnose within artificial and largely irrelevant legal categories.

Arguments in favour

3.11 Requiring a finding of mental disorder in each case restricts the category of people to whom procedures which are both coercive and protective may be applied by purely diagnostic means. In this respect it does rely on a "status" hurdle. However, because assessing the person's ability to understand and function in a particular decision-making process may constitute the next stage of the test it does not follow that those who are mentally disordered are automatically deemed mentally incapable. The requirement serves a gate-keeping function and once mental disorder has been established it should then be possible for different kinds of cognitive incapacity to be sensitively identified. Not to have a threshold of mental disorder, it can be argued, places too heavy a burden on the functional test: as we shall see later, this test is not easy to define or to apply, particularly as to the *degree* of incapacity which is required. Further, requiring proof of mental disorder should increase the involvement of people with suitable specialist qualifications in the determination of whether intervention is necessary in an individual case, and what kind of intervention is most appropriate.

3.12 Another significant argument in favour of a "disability hurdle" arises from the provisions of the European Convention on Human Rights.[12] In the *Winterwerp* case[13] the

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[12] The United Kingdom has both ratified the Convention and granted the right of individual petition, and the European Court of Human Rights is developing an increasing and influential body of case-law. In so far as English law is not clear, whether statute law or the common law, it must be interpreted by English courts with a predilection to ensure that there is not breach of relevant provisions of the Convention (see for example *Attorney-General* v. *Guardian Newspapers (No 2)* [1990] 1 A.C. 109, at p.283 and *Derbyshire County Council* v. *Times Newspapers Ltd.* [1992] 1 Q.B. 770). We assume that it is our duty to ensure that any proposals for new legislation take into account the international

European Court of Human Rights considered Article 5(1)(e) of the Convention, which states that:

> "Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law...
> (e) the lawful detention of persons...of unsound mind."

The Court considered that the Article required that "unsoundness of mind" had to be reliably shown on the basis of "objective medical expertise" and the disorder must be of a kind warranting confinement, the validity of continuing custody depending upon the persistence of such a disorder.[14] It can be argued that substitute decision-makers who have the power to decide incapacitated people's places of residence, take them there and return them if they leave are in fact "detaining" them.[15] The restraint methods used in residential homes, particularly for the elderly, have recently had adverse publicity.[16] If the State appoints or allows someone to choose an incapacitated person's residence and a home is chosen which uses such tactics (including a private family home), it could be that the State is in breach of the Convention unless the *Winterwerp* conditions are fulfilled, and in particular the condition requiring true mental disorder on the basis of objective medical expertise.[17]

3.13 From the responses received to our consultation paper it appears that more distress is caused by over-extensive use of protective powers than by any stigma found to attach to the term "mental disorder". It also seems that the requirement goes at least some way towards

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obligations of the United Kingdom under the Convention.

[13] *Winterwerp v. The Netherlands* (1980) 2 E.H.R.R. 387.

[14] *Ibid.*, p. 403. For a further discussion see Berger, *Case Law of the European Court of Human Rights*, Volume I (1989), para. 235.

[15] It must be borne in mind that breaches of Article 5 can only be alleged as against States. The right of petition would be preserved if the person has been detained under a power granted in a statute or by a national court or tribunal.

[16] See above para. 2.17 and n.22.

[17] See also para. 2.17 and n.21 above.

providing a safeguard against improper interference in the lives of those whose perceived failure to manage is attributable merely to a lack of inclination or eccentricity.

3.14 We tend, therefore, to favour the inclusion of a requirement of mental disorder, although we recognise that there may have to be specific extensions in relation to some other conditions or in some other contexts. We therefore provisionally propose that:

> **2. Unless the person concerned falls within a listed exception (see discussion below), it must be established that he or she is suffering from a mental disorder or disability.**

The definition of mental disorder

3.15 There are arguments for altering the existing definition of "mental disorder" in section 1 (2) of the Mental Health Act. It should be noted that this wide definition of mental disorder already embraces types of disorder which by themselves would be insufficient to ground an application for compulsory admission to hospital.[18] It includes all those with learning and other disabilities resulting, for example, from head injuries, where those injuries are not serious enough to constitute overt mental illness or psychopathic disorder. However, the 1983 Act does specifically exclude certain conditions that might be thought to come within the very broad definition of "any other disorder or disability of mind." Section 1(3) provides that a person cannot be found to suffer from "mental disorder" by reason "only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs".

Arguments in favour of amendment

3.16 At least one of our respondents argued that those afflicted by crippling dependencies on alcohol or drugs are "left without help" because they are excluded from the existing definition of "mental disorder". Many ordinary people might think that addictions which lead to ruinous behaviour and are beyond the power of sufferers to control must be comprised

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[18] i.e. under the Mental Health Act 1983, ss. 2-4.

within the term "mental disorder". There is also doubt as to whether persons who indulge in compulsive high-risk behaviour (particularly gambling) would come within the jurisdiction of the Court of Protection, although some consider that behaviour likely to lead to major dissipation of assets does do so.[19] None of our respondents suggested that the existing exclusions in relation to sexual behaviour were inappropriate, and we think it may be advisable to retain them when we propose that substitute decision-making should be extended to personal and lifestyle matters. For the same reason, it might be thought desirable to extend the list of exclusions, perhaps in relation to religious, political or cultural beliefs.

Arguments for retaining the existing definition

3.17 At present although dependence on either alcohol or drugs may not of itself establish mental disorder the statutory definition would cover those cases where the dependency co-exists with a "qualifying" mental disorder. The existing definition *is* also sufficiently wide to embrace chronic cases where continued abuse of drugs, alcohol or other toxic substances results in a "psychiatric" disorder. It is argued that although the profligate behaviour of drug- or alcohol-dependent people does often cause great distress to friends and relatives this does not transform addiction into "mental disorder" and is insufficient reason to interfere with people's rights to behave as they wish. As for the significance of religious, political or cultural beliefs, these should be dealt with in guidance for those assessing "mental disorder" rather than in any statute itself.

3.18 Our present view is that there is no need for change. We therefore provisionally propose:

> **3. "Mental disorder" should for this purpose be defined as in section 1(2) of the Mental Health Act 1983 and the exclusions set out in section 1(3) should be retained.**

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[19] See the Notes to accompany the Certificate of Incapacity (form CP3) which advises doctors that the Court tends to the view that such cases fall within its jurisdiction.

The definition of incapacity

A cognitive, or function, test

3.19 Whether or not there is to be a precondition of mental disorder or disability, we are of the view that any new jurisdiction should, as does the present law, generally apply a test of cognitive functioning.[20] Cognitive ability is the ability to arrive at a decision by manipulating information and making a choice.[21]

3.20 A number of other countries have, in very recent years, constructed cognitive tests as gateways to reformed guardianship jurisdictions.[22] Legislation in New Zealand provides that the court has jurisdiction in respect of a person who:

> "lacks, wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare."[23]

There is no disability precondition; this test has therefore to discharge the whole burden of identifying those who should be covered by the jurisdiction, while excluding those who should not. Although we favour the cognitive emphasis of the test, we fear that the apparent simplicity of the language cloaks an extremely elusive concept. The existing common law tests of capacity have been developed in relation to particular actions, contracts or documents. Activities and documents and medical treatments may indeed have fairly clearly identifiable

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[20] We deal below with cases where cognitive "functional" disability is *not* established but there may be an argument for including clients who cannot communicate or lack free will.

[21] See further Consultation Paper No. 119, paras. 2.37 - 2.41.

[22] Compare the test in Ontario's Substitute Decisions Bill 1991 clause 46 - "not able to understand information that is relevant to making a decision...or...not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision" - with the older test in Alberta's Dependent Adults Act 1976 (as amended), s.6 - "unable to care for himself and to make reasonable judgements." The pioneering Australian jurisdiction, Victoria, provides in its Guardianship and Administration Board Act 1986, s.22(1)(b) that the client must be "unable...to make reasonable judgements..."

[23] Protection of Personal and Property Rights Act 1988, s. 6(1)(a).

"natures". On the face of it, however, the New Zealand formulation requires the person to understand the nature of the decision-making process itself. Whilst we agree that it is the person's understanding which should be assessed, we think that it is the person's ability to understand *information*, rather than "a decision" which is the real point.

3.21 The Scottish Law Commission found the New Zealand test attractive, but were concerned about those "who can make a decision ... but cannot remember what they have decided or translate it into effective action".[24] In the tentative test in their recent Discussion Paper, they replaced "consequences" (in the New Zealand formulation) with "possible implications", and added an alternative that the person "has such capacity but is unable to ... act consistently in accordance with such decisions."[25] We think the concept of "possible implications" even vaguer than that of "consequences". Pregnancy is a possible consequence of a decision to have unprotected intercourse, but what are its implications? Nor are we attracted by the introduction of the ground of inability "to act consistently", since it brings people who have functional ability into the scope of the jurisdiction. Whilst there may be arguments for including other types of people within the jurisdiction, we do not think that they should be slipped in through the definition of cognitive incapacity. We have less difficulty with the inclusion of those who cannot remember the relevant information for long enough to make an effective decision, for we see this as a cognitive incapacity. We suspect that it is not the failure to act which justifies intervention, but rather the mental inability to appreciate the result of failing to act.

3.22 We therefore prefer an approach similar to that recently put forward in Ontario, and in Alberta and Newfoundland in relation to medical decisions, which concentrates upon the person's ability to understand the information relevant to the decision and to appreciate its reasonably foreseeable consequences.[26] This has the merit of expecting the assessor to give the person that relevant information as part of assessing his or her competence to decide.

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[24] Discussion Paper No. 94, para. 2.62.

[25] *Ibid.*, para. 2.62, clause 5 (1) (a).

[26] Alberta Law Reform Institute, Advance Directives and Substitute Decision-Making in Personal Health Care (1991), p.62; Newfoundland Law Reform Commission, Discussion Paper on Advance Health Care Directives and Attorneys for Health Care (1992), p.72.

Furthermore, this would include information about its consequences, for an ability to appreciate its consequences is different from an ability to foresee consequences which no-one has tried to explain.

3.23 A further question relates to the amount and complexity of the information which the person might have to be able to understand. The present law generally sets the threshold of understanding quite low, by requiring only a capacity to understand what is proposed in "broad terms". We consider that this approach is consistent with the desire to enable people to take as many decisions as possible for themselves and to limit intervention to the most serious cases. It is also consistent with the view recently expressed in the Court of Appeal that the greater the gravity of the consequences of any decision, the greater the degree of understanding required.[27]

3.24 We therefore invite views on the following definition of cognitive incapacity:

> **4. A person should be considered unable to take the decision in question (or decisions of the type in question) if he or she is unable to understand an explanation in broad terms and simple language of the basic information relevant to taking it, including information about the reasonably foreseeable consequences of taking or failing to take it, or to retain the information for long enough to take an effective decision.**

3.25 If it is feared that a function test along these lines is not strong enough, interference in the lives of the merely deviant or eccentric could be expressly excluded. New Zealand law provides that the fact that the client "has made or is intending to make any decision that a person exercising ordinary prudence would not have made or would not make is not in itself sufficient ground for the exercise of [its] jurisdiction by the Court."[28] A similar safeguard is proposed by the Scottish Law Commission, with a stipulation that "the fact that the person has acted or intends to act in a way an ordinary prudent person would not act should not by

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[27] *Re T* [1992] 3 W.L.R. 782.

[28] Protection of Personal and Property Rights Act 1988, s. 1(3). .

itself be evidence of lack of capacity."[29] We, however, doubt the need for any such stipulation, in the light of the definition we have proposed, which clearly directs an assessor to the decision-making process, rather than its outcome. We invite views on this.

Should other decision-making problems be included?

3.26 It may not always be clear under the existing law whether what is being applied is a true cognitive test. The test applied by the Court of Protection asks whether a person is "incapable by reason of mental disorder of managing his property and affairs."[30] It might be argued that inability to "manage" is different from inability to understand the information relevant to managing. Generally speaking, however, the two will be the same: in order to manage, a person needs to understand what bills have to be paid, the consequences of not paying them, and the resources available to pay them. However, it is sometimes argued that there are people whose understanding is adequate but who are nevertheless in need of the law's protection.

(i) *A rationality test?*

3.27 At least one respondent to our consultation paper suggested that any test of understanding should be extended by the requirement that the decision in question must be a "rational" decision. It was suggested that this would embrace those cases where the process of reasoning was so distorted as to call for paternalistic intervention. It was acknowledged that it would be necessary to spell out that a decision may be rational even though it differs from the decision most people would make. A "rationality" requirement is not the same as a "reasonableness" requirement.[31]

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[29] See Discussion Paper No. 94, para. 4.40.

[30] Mental Health Act 1983, s.94(2).

[31] Legislation in both Alberta and Victoria looks to the "reasonableness" of the judgments made by the subject person. See para. 3.20, n. 22, above.

Arguments in favour

3.28 It can be argued that some consideration of outcome is an essential component of any test of incapacity because a person who has sufficient understanding but nevertheless goes on to make a choice which is contrary to what would be expected of the vast majority of adults falls short of our common sense understanding of what it is to have mental capacity. For example, someone who understands what is involved in placing a bet (as well as the high odds against winning) and foresees the consequence of losing, may go on to place a bet simply because he or she enjoys taking risks. However, where the possible consequences are disastrous, such that no reasonable person could accept the consequence of making that choice, then it might be argued that the person lacks capacity. Further, if the test is linked to the requirement that such incapacity must be the result of mental disorder, people would not be included simply because they enjoy their eccentricity or risk taking activity.

3.29 A "rationality" requirement might also bring in those people who are unable to exercise their cognitive abilities because of their dependence on alcohol or drugs. They might be the first to admit that their continued abuse of whichever substance is a perverse outcome, given their understanding of the harm they are inflicting on themselves and others. Especially in relation to financial matters, it might be thought justifiable to control the decision-making of such persons.

Arguments against

3.30 It is not in practice possible to distinguish between requiring a rational process of reasoning and requiring a rational outcome. This test would inevitably slide into an assessment of the "reasonableness" of a particular decision which could not be applied in an objective and non-discriminatory way. The reasons why a particular person makes a particular decision may or may not be regarded as rational by the person assessing his or her competence to make it, but it is of the nature of decision-making that different people will make different decisions because they give greater weight to some relevant factors than to others: their own particular values and preferences can be taken into account. It can be argued that it is important to preserve the "right to be wrong". In our view these arguments are far

more compelling than those in favour of a "rationality" test, which did not attract a significant level of support from respondents. We do not therefore propose it.

(ii) *A "true choice" test*

3.31 However, the reason we require a capacity to understand information is so that the person concerned has a basis on which he or she can make a choice. If that person is subject to a compulsive mental disorder which determines that choice then the information is of no use. It may here be relevant to note that there have been many suggestions for extending the cognitive approach to capacity in the criminal law to include "irresistible impulse" cases within the M'Naghten Rules. There may therefore be a case for including within the definition those who understand the relevant information but by reason of their mental disorder are unable to make a genuine choice based upon it.

3.32 There is another reason why some mentally disordered or disabled people may be unable to exercise a real choice. The policy of care in the community will inevitably increase the opportunities for people who may be unable to protect their own interests to engage in commercial transactions. Living in the community will present people who might once have lived in institutions where there were few decision-making possibilities with what may be a bewildering array of choices. The consultation paper pointed out that people with a mental handicap have often been accustomed from childhood to doing as they are told, and may be more vulnerable than most to pressure and persuasion.[32] The argument turns on the concept that a person's independent will can be overborne by others, so that the decision arrived at is not "a true decision."[33]

Arguments in favour

3.33 Those with mental disorder or disability may be especially vulnerable to pressure being exerted to their disadvantage and it may be entirely appropriate to have special

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[32] Consultation Paper No.119, para. 1.5.

[33] *Re T*, [1992] 3 W.L.R. 782, 799, *per* Lord Donaldson M.R.

provision for them. No decision which is a result of a person's will being overborne should be accorded any weight. The same argument may be applied to a person whose will is overborne, not by the actions of others but by the effects of his or her own disorder. The equitable doctrines which allow transactions to be set aside[34] are complex creations of case-law which are little understood and come into play after the event when the allegedly vulnerable party may no longer be able to give evidence. A jurisdiction which could pre-empt arguments by exploring the issues in advance and making any appropriate orders would be a great advance on the existing law.

Arguments against

3.34 If this test is linked to a "mental disorder" requirement, then it might be argued that special powers are being given to control the disordered and vulnerable where none exist in relation to the non-disordered and vulnerable. This could be seen as discriminatory. The suggestibility of, in particular, mentally handicapped people, may in large part be caused by the fact that they have not been given the opportunity to learn how to make choices. Rather than stigmatise them as incapacitated it would be preferable to help them to learn to do this. This argument does not apply with equal force to those with compulsive disorders. Nevertheless the equitable doctrines may be thought sufficient, and capable of development in a flexible way.

3.35 We tend to the view that the test should include those who have cognitive ability but are prevented by reason of their mental disorder from the exercise of independent will. This could be because of the compulsions or the vulnerability to pressure contained within the disorder itself. We therefore provisionally propose:

5. A person should be considered unable to take the decision in question if he or she can understand the information relevant to taking the decision but is unable because of mental disorder to make a true choice in relation to it.

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[34] See *Chitty on Contracts* (26th ed., 1989), paras. 522 - 542.

Should anyone else be included?

3.36 If the capacity test (with or without mental disorder) is left to stand alone, circumstances may arise where those in need of, and asking for, assistance are turned away because there is no jurisdiction to deal with their case.

(i) *Jurisdiction by consent?*

Arguments in favour

3.37 For example, a young mentally disabled man might wish to see an absent parent, relative or even friend, disapproved of by his carer. He might be functionally able to make that decision, and to exercise independent will in relation to it. He might, however, wish for an order to assist him in putting the decision into effect, against the wishes of the carer. Similarly, a carer might wish to apply for an order to protect a mentally disabled woman from molestation but the court or tribunal might not be satisfied that the disabled person is unable to take proceedings in her own name and give instructions. If the person concerned is required to seek a remedy through an entirely separate set of proceedings as a result of a determination of capacity extra costs will inevitably be incurred. It can also be argued that a specialist jurisdiction will be more appealing to disordered or disabled people, in that the adjudicating body will have special expertise and procedures.[35]

Arguments against

3.38 It can be argued that in situations where incapacity cannot be established the person concerned may have recourse to the general law. A person who is not incapacitated should be presumed competent to contact the social services department, the police or a lawyer. If legal remedies are really necessary in the situations described above, injunctions can be granted in proceedings for trespass to the person or in the domestic violence jurisdiction to

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[35] In its recent Discussion Paper, the Queensland Law Reform Commission suggested that jurisdiction to intervene *should* be available wherever the subject person consents: Queensland Law Reform Commission Discussion Paper No. 38 *Assisted and Substituted Decisions* p. 27.

enable a person to assert his or her rights. If the jurisdiction is not founded on legal incapacity there is nothing to distinguish it from any other jurisdiction. We tend to the view that the jurisdiction cannot be extended by reference to the consent of the person concerned, if he or she is not legally incapacitated. We invite comments on this matter.

6. The new jurisdiction should not extend to those who are not legally incapacitated in relation to a particular decision but who request or consent to the making of an order in relation to themselves.

(ii) *Inability to communicate?*

3.39 The consultation paper recognised that some people might be suffering from an inability to communicate rather than an incapacity to make any decision.[36] A number of our respondents dealt with this point, highlighting the difficulty of cases where it was unclear whether the person was incapable of decision-making or merely of communicating, and agreeing that there were cases where the inability to communicate could not be overcome.

3.40 We take the view that people unable to communicate their decisions may well need someone else to act on their behalf, and they should not be left without a solution to their difficulty. Since it is important not to designate incapable of decision-making those who are not, we favour specific provision for those incapable of communicating. The New Zealand legislation pointedly limits its jurisdiction to those *wholly* incapable of communication.[37] This might answer the fears of those respondents who were concerned that people might be included simply because insufficient effort had been made to understand them. These fears might be allayed by appropriate guidance on testing. Problems might however still arise where insufficient effort had been made to find an appropriate interpreter, for example where a person was deaf and dumb.

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[36] Consultation Paper No. 119, para. 1.8.

[37] Protection of Personal and Property Rights Act 1988, s.6(1)(b).

3.41 While we have argued that separate provision must be made for those unable to communicate we are concerned with the situation of those whose communication difficulties are severe but not total. It may be that they could communicate in certain conditions but this is not reasonably practicable in the circumstances in which the decision has to be made. We think the question is not whether the inability is general or partial but whether the person can communicate the particular decision at the time it has to be made to a person who has made reasonable attempts to understand. As that inability might be the result of physical disabilities or simply not ascribable to one condition or another the requirement of mental disorder or disability should, therefore, not apply. We provisionally propose that:

7. A person should be considered unable to take the decision in question if he or she is unable to communicate it to others who have made reasonable attempts to understand it.

Standard of proof

3.42 As was said in the consultation paper, there is an argument for applying the criminal standard of proof to an enquiry into mental incapacity. The argument is founded on the perceived "drastic consequences" of an adverse finding.[38] However, this argument takes a purely negative view of intervention, whereas it has its positive side, and can both protect and benefit the person concerned. Some commentators have argued for an intermediate standard of proof, higher than the normal civil standard - the "clear and convincing" standard.[39] In fact, however, although the normal civil standard is the "balance of probabilities", this is qualified by the requirement that the graver the consequences the greater the standard of proof required. We consider that this is entirely appropriate and therefore provisionally propose:

8. The standard of proof in relation to findings of legal incapacity should be the standard of proof in civil proceedings.

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38 Consultation Paper No. 119, para. 4.19.

39 New Zealand Institute of Mental Retardation, *Guardianship for Mentally Retarded Adults: Submissions to the Minister of Justice* (1982), p. 20.

Summary

3.43 In summary, we provisionally propose that any new jurisdiction should be available in respect of people of or over the age of 16 who meet either of the following criteria:

(1) **They are (a) suffering from mental disorder within the meaning of the Mental Health Act 1983 and**
(b) either (i) unable to understand an explanation in broad terms and simple language of the basic information relevant to taking the decision in question, including information about the reasonably foreseeable consequences of taking or not taking it, or to retain that information for long enough to take an effective decision or (ii) unable by reason of their mental disorder to make a true choice in relation to that decision.

(2) **They are unable to communicate the decision in question to others who have made reasonable efforts to understand it.**

3.44 We have considered but provisionally rejected (1) an express provision that a person is not within the jurisdiction simply because he or she makes decisions which an ordinary prudent person would not make; and (2) the inclusion of people who may not fall within the above criteria but have applied for or consented to the exercise of the new jurisdiction. However, we specifically invite views on both these questions.

PART IV

ADMINISTRATIVE AND JUDICIAL DECISION-MAKING

Introduction

4.1 We have already discussed the position of family and carers and whether there is a case for putting on a statutory footing the informal decision-making which currently and lawfully takes place. Whatever the outcome, there are obviously some decisions which have to be taken at another level. There may be many decisions which call only for the involvement of an administrative authority, such as a local social services department or a central government department.[1] Both informal and administrative decisions should, however, be subject to review by a judicial authority at the instance of a person legitimately concerned. There may be some extremely serious decisions which should only be made either by or on the authority of a judicial forum. A judicial forum is also needed for the resolution of a variety of disputes. We shall postpone discussion of what that forum should be until the nature and scope of its jurisdiction has become clearer.

The administrative level

4.2 A number of substitute decision-making procedures already operate at an administrative level. The Court of Protection as now constituted spans the administrative and judicial tiers. In spite of its name, the Court of Protection "is not, however, a Court as such; it is merely the title of an office."[2] It undoubtedly has judicial powers, exercised by the Master, Assistant Master and nominated officers (civil servants). It also has administrative functions, now carried out by (civil servants in) the Protection Division of the Public Trust

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1 The Department of Social Security administers the social security appointee scheme, and the Protection Division of the Public Trust Office performs administrative functions at the direction of the Court of Protection.

2 Heywood & Massey, *Court of Protection Practice*, (12th ed., 1991), p.8.

Office.[3] Matters which are complex, disputed or involve large sums of money will be referred to an appropriate person in the "judicial" chain. Straightforward administrative matters - such as the checking of annual receivership accounts, or the processing of applications for registration of an enduring power of attorney - will be dealt with within the Public Trust Office. Although the general form of first application to the Court of Protection is still printed with blank spaces for a hearing date (like many other court forms) the reality is that the Court dispenses with hearings in the majority of cases, conducting much of its business by post. After an initial order has been made, the procedure becomes even less court-like, with applications and authorisations granted on the basis of correspondence. The scheme for appointees under the Social Security Regulations is exclusively "administrative" in nature. In personal care matters, the guardianship scheme under the Mental Health Act operates at an administrative level, that of the local social services department, albeit with appeal rights to a judicial body, initially a Mental Health Review Tribunal.[4]

4.3 There may be scope for extending or rationalising the number of substitute decisions for the incapacitated which can be taken without the involvement of a judicial body. Many respondents were anxious that any body involved with the regulation of the affairs of the incapacitated should have local offices (as do social services departments and the Department of Social Security). We deal in later parts with decisions which might be capable of at least initial resolution by an administrative body.

4.4 There is also a role for an administrative body in cases where the judicial forum has made an order but seeks continuing supervision or review of the situation. In financial matters, there is clearly a need for a body which administers property on behalf of incapacitated persons, as the Protection Division does at present. In personal care matters there may also be a role for an administrative body with a supervisory function.

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[3] *Ibid.*, p.9.

[4] Mental Health Act 1983 s.7. It must be borne in mind that this scheme is not concerned with the incapacitated, but with those suffering from specified forms of mental disorder.

A "best interests" criterion

4.5 We think that any administrative body which is able to take or authorise a decision on behalf of an incapacitated person should have the same guidance as any carer as to the best interests of the client.[5] This will mean, inter alia, that the body must take into account the wishes and feelings of the incapacitated person and involve the incapacitated person in the decision-making process to the greatest extent practicable. Hence we provisionally propose:

1. Where a decision is taken by an administrative body on behalf of an incapacitated person, that body should have a duty to act in the best interests of the incapacitated person, taking into account:

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

The judicial level

4.6 There already exists a judicial forum for the legitimation of substitute decision-making and the resolution of certain disputes in relation to the "property and affairs" of a mentally incapacitated person. The present statutory jurisdiction of the Court of Protection is descended from the prerogative powers of the Crown, which extended to the person as well as the property of persons of unsound mind. At present, however, there is no such jurisdiction in

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[5] See para. 2.15 above.

relation to personal care and welfare. In relation to certain very serious types of medical treatment, the declaratory jurisdiction of the High Court has been adapted to fill the gap.

4.7 It is clear from our consultation that this is unsatisfactory, for three broad reasons. First, there may be just as much need to legitimate substitute decision-making or to resolve disputes about personal care as there is about a person's property and affairs. Secondly, the two often go hand in hand, so that the present rigid separation between the powers of the Court of Protection and those of the health and welfare authorities is artificial and limits what can be done to help the mentally incapacitated person. Thirdly, while it may very well be appropriate to involve the High Court in the most important decisions, there is a need for a lower, less formal and less expensive level of decision-making. This should bring together the present judicial functions of the Court of Protection with the new jurisdiction which we propose for matters of personal care. Hence we provisionally propose that:

2. There should be a new jurisdiction bringing together the judicial functions of the Court of Protection with similar functions in relation to matters of personal care and welfare.

4.8 Matters may arrive at the judicial level because the decisions of carers are being challenged, or by appeal from an administrative decision, or because an issue arises which is specifically reserved for judicial determination. We would not, however, anticipate that this would often be necessary. The intervention of a judicial authority should be a matter of last resort. A test of "need" is often a final limb of the test for court intervention in the reformed jurisdictions elsewhere.[6] Another model requires that any order "benefit" the person

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[6] Alberta's Dependent Adults Act 1976 (now amended) required the Court to be satisfied that the dependent person was "in need of a guardian." Victoria's Guardianship and Administration Board Act 1986 has a requirement that the subject person be "in need of a guardian." Ontario's Substitute Decisions Bill allows the court to appoint a guardian to an incapable person who "as a result, needs decisions to be made on his or her behalf."

concerned.[7] Guidance as to the principles the court should apply in exercising its discretion is favoured.[8]

4.9 In their Discussion Paper, the Scottish Law Commission favoured restricting the court's jurisdiction to cases where "legal authority" is required or de facto care or control being abused. They suggested a requirement that :

> "the appointment of a personal guardian or the making of some other order would result in a substantial benefit to, or necessary protection of, the person."[9]

4.10 Another model can be found in the "better than no order" test in the Children Act 1989.[10] Clearly, the law relating to mentally incapable people should not be entirely analogous to child law. Nonetheless, a balancing of personal rights with protective measures has to be achieved in both fields. In both, the undesirability of formal, intimidating and expensive procedures "about" delicate human lives should properly be borne in mind.

4.11 The alternative criteria of "need" and "benefit" can be related to the negative and positive sides respectively of the normalisation principle. "Need" assumes that intervention is bad and must be justified. If strictly applied, it will rule out the making of an order where the application is based on a reasonable apprehension of a future difficulty.[11] A number of

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7 Alberta's Dependent Adults (Amendment) Act 1985 amended the 1976 Act by removing the "in need of a guardian" test and substituting a requirement that an order "(a) be in the best interests of, and (b) result in substantial benefit to" the person the subject of the application.

8 New Zealand's Protection of Personal and Property Rights Act 1988 s.8 sets out "primary objectives" to which the court must have regard, broadly, "least restrictive intervention" and "maximisation of potential". The Victoria Act (s.22(3)) stipulates that an order must be "in the best interests of" the subject person.

9 *Op. cit.* p.51.

10 "Where a court is considering whether or not to make one or more orders under this Act with respect to a child, it shall not make the order or any of the orders unless it considers that doing so would be better for the child than making no order at all." Children Act 1989 s.1(5).

11 This has been the approach of Victoria's Guardianship and Administration Board, confirmed on appeal to the Administrative Appeal Tribunal in *Re M and R* (1988) 2 VAR 213 and *Re E* (1988) 2 VAR 222. Recent research indicates some consumer dissatisfaction with the Victoria tribunal's refusal to

our respondents stressed the desire of carers to make future (i.e. "speculative") provision for the people in their care. "Benefit" acknowledges that intervention could be good and therefore merited. This appears to us a preferable emphasis. We think that the qualification comprised in the addition of the adjective "substantial" may tip the balance too far.

4.12 It is possible to place a person under Mental Health Act guardianship, where this is necessary, not for his own welfare, but "for the protection of other persons."[12] Some of our respondents did refer to the difficulties caused to carers and others by the behaviour of some incapable people. However, we tend to think that direct intervention for the protection of third parties is a function of the public rather than the private law. Our present view is that any "private law" jurisdiction should be confined to orders that will benefit the incapacitated person. We therefore provisionally propose that:

> **3. Having found that a person is incapacitated in relation to the function in question, the judicial authority must be satisfied that the making of an order will bring greater benefit to the incapacitated person than making no order at all.**

4.13 In most other jurisdictions, court intervention in relation to the decision-making of an incapacitated adult can take only one form, the appointment of a proxy decision-maker. Appointments are now often very limited in both scope and duration.[13] However, we think it preferable that, wherever practicable, the judicial authority should itself resolve the particular issue with which it is confronted, rather than delegate decision-making power to another person. This is consistent with the presumption of capacity and with the principles of normalisation and the "least restrictive intervention". We deal in Parts V and VI with the types of order we propose in the financial and personal care fields respectively. In both, however, we propose that the judicial authority should have power to deal with specific issues and to appoint a manager with continuing powers of substitute decision-making. In principle,

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countenance "speculative" guardianship orders (T. Carney and D. Tait, *Balanced Accountability: An evaluation of the Victoria Guardianship and Administration Board* (1991)).

[12] Mental Health Act 1983 s.7(2)(b) - "it is necessary in the interests of the welfare of the patient or for the protection of other persons that he should be so received [into guardianship]."

[13] Alberta's Dependent Adults (Amendment) Act 1985 abolished the concept of plenary guardianship as such, and provided that any order must specify the powers being granted to the guardian.

however, we think that specific issue orders are to be preferred to the appointment of managers, and that whatever order is made should be as limited in scope as possible. Hence we provisionally propose that:

4. The judicial authority should have power both to resolve specific issues and to appoint proxies to manage the incapacitated person's personal care and welfare and/or property and financial affairs.

5. An order dealing with a specific issue is to be preferred to the appointment of a manager, unless there is a need for a continuing authority, and any order should be as limited in scope as possible.

4.14 The judicial authority should also be governed by the same principles as those governing the decisions and actions of carers and administrative bodies. Hence we also provisionally propose that:

6. Any order made should be in the best interests of the incapacitated person, taking into account:

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable;

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

4.15 We now turn to consider the precise range of powers which should be available to administrative and judicial authorities in relation to the financial and personal affairs of an incapacitated person.

PART V

FINANCIAL DECISION-MAKING

Introduction

5.1 When considering issues of substitute decision-making and financial management a distinction needs to be drawn between (i) access to funds held by or due to the incapacitated person, and (ii) the authority of a carer or other person to use such resources on behalf of the incapacitated person. At present there are a number of mechanisms whereby a person may obtain periodic or other payments from a statutory or other body provided that those in a position to make such payment are satisfied both as to the suitability of the proposed "receiver"[1] and the incapacity of the person with whom they would normally deal. Although some of the paying authorities stipulate that payments must be spent for the incapacitated person's benefit there are few procedural safeguards and little opportunity in practice to monitor the performance of the informal "receiver" once he or she has been appointed.

5.2 By contrast, any Receiver appointed by the Court of Protection[2] must, unless the Court otherwise directs, give such security for the due performance of his or her duties as the Court may approve.[3] Further, unlike the type of "receiver" or appointee appointed by a paying body, a Receiver appointed by the Court of Protection acts under the authority of the

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[1] In general a receiver is a person appointed for the collection as well as the protection of property. In the Court of Chancery the term did not include someone appointed to manage property. "The receiver merely took the income, and paid necessary outgoings, and the manager carried on the trade or business": see *Re Manchester & Milford Ry. Co., Ex parte Cambrian Ry. Co.* (1880), 14 Ch. D. 645, C.A. *per* Jessel, M.R., at 653. We understand that in the Chancery Division the distinction still applies.

[2] The Court usually appoints a near relative to act as Receiver. In 1990, 62.6% of patients had a relative acting as Receiver as compared with 13.6% who had solicitors and 8.3% whose Receiver was their local authority: see Mrs A.B. Macfarlane, *The Court of Protection*, Med. Leg. J. (1992) 60(1), p. 31, fig. 6.

[3] Mental Health Act 1983, s.107(1) and Court of Protection Rules 1984, S.I. 1984, No. 2035, rr.55 - 59.

Court and must by statute render accounts annually or as otherwise directed.[4] If the Receiver fails in this duty or fails to act in accordance with the directions of the court, the security which he has given (usually in the form of a guarantee bond) may be claimed by the Court. Lastly, the Court has extensive powers to order an investigation into the patient's affairs.[5] These inquiries may include the desirability of appointing a Receiver, an inspection of the client's property and testamentary documents, any prior dealings with the client's property and any other inquiry which the court considers "necessary or expedient" for the proper discharge of its functions.[6]

5.3 It can be seen that the Court of Protection, with the assistance of the administrative functions carried out for it by the Public Trust Office, is empowered to appoint and regulate (with specific sanctions) an individual financially to manage another person's property and affairs. That individual's responsibility goes beyond simply "receiving" payments and using them for the client's benefit. A Receiver appointed by the Court of Protection must manage the patient's income, comply with directions given by the Court (often communicated through delegated authority) concerning capital, and as stated above, account for all transactions on the client's behalf on an annual basis.

5.4 While few of those who responded to our consultation paper criticised the jurisdiction of the Court of Protection for failing adequately to protect a patient's property and affairs many considered that its effect in some cases was like "using a sledgehammer to crack a nut". In this Part we consider whether the functions (judicial and administrative) carried out now by the Protection Division[7] may properly be included within the new jurisdiction. If this were a favoured option we would propose that the present jurisdiction conferred by Part VII of the Mental Health Act 1983[8] should remain intact but that: (i) the Court be encouraged to deal

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4 Mental Health Act 1983, s.107(2) and Court of Protection Rules 1984, rr.60 - 64.

5 The inquiries may be carried out either by an officer of the court, one of the Lord Chancellor's Visitors or the Official Solicitor.

6 See the Court of Protection Rules 1984, rr.66 - 70.

7 Which includes the Court of Protection and the Public Trust Office.

8 i.e. that Part which deals with the management of patients' property and affairs.

with financial problems by means of a single issue order[9] and (ii) that the procedures of the Court differentiate between incapacity which is of a nature or degree such that a client is unable to manage his or her property and affairs without the assistance of a financial manager and incapacity which affects only one or some aspects of financial management. We discuss below a number of proposals which relate to the appointment and regulation of substitute decision-makers which, at each level of formality, seek to maximise protection for the incapacitated person within the aims of policy as set out in the previous parts of this paper.

5.5 An application to the Court of Protection may be unnecessary where other methods of managing the person's affairs are available and these are discussed below.[10]

Access to funds held by or on behalf of an incapacitated person

5.6 There are two statutory schemes whereby (i) social security benefits[11] and (ii) periodic payments of salary, pension or other similar payment by Parliament (or payment administered by or under the control or supervision of a government department)[12] may be paid directly to the institution or person caring for an incapacitated person to be applied for his or her benefit. Various other discrete statutory powers exist.[13] For example, under

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9 This could probably be achieved simply by amendment to the Court of Protection Rules, see further paras. 5.25 - 5.26 below.

10 The duty of a local social services authority to protect "any movable property" of a person in need of care and attention under the National Assistance Act 1948, s.48 will be considered elsewhere.

11 See Social Security (Claims and Payments) Regulations 1987, S.I. 1987, No. 1968, reg. 33.

12 Mental Health Act 1983, s.142(1). The government department must first be satisfied, after considering medical evidence, that the person in question is incapable by reason of mental disorder of managing and administering his or her property and affairs. The authority may pay the sum or such part of it as they think fit: (i) to or for the benefit of the person's family or to other persons for whom the patient might be expected to provide if he or she were not mentally disordered; or (ii) to reimburse people who have paid his or her debts (whether enforceable or not) or helped to maintain either the person concerned or his or her family: (s.142(2)).

13 See also provisions in the Industrial and Provident Societies Act 1965, s.26 (payment of shares, loans, and deposits to a proper person after consideration of medical evidence to establish the member is "incapable through disorder or disability of mind of managing his own affairs"); and payments under the Vaccine Damage Payments Act 1979, s.6 (payment to such trustees as the Secretary of State may appoint).

National Savings Bank Regulations,[14] a discretion is given to pay money to those looking after a mentally incapacitated adult. We consider below whether there is a case for extending this type of statutory power to a wider range of institutions such as banks, building societies and insurance companies. Lastly, money is often held by hospitals for patients. Whether the sums involved comprise state benefits, "pocket money" (provided by the Secretary of State under the Mental Health Act 1983) or the patient's personal resources much criticism has been levelled at hospital administrators for failing to help patients either claim those benefits which they are entitled to or spend what money has accumulated in a planned and imaginative way.[15]

Social security appointees

5.7 At present, people who live on state benefits or do not have property of their own may not be considered to be in need of the help of the Court of Protection. This is because the Department of Social Security has power to appoint an appointee to receive and administer income support[16] or social security benefits payable to someone who is "unable to act".[17] There are no guidelines on the question of whether someone is unable to act, although the Income Support Manual, which gives guidance only in the area of Income Support, does state that: "a person is unable to act because they do not have the mental ability to understand and control their own affairs, for example, because of senility or mental illness".[18] Although medical evidence of either mental disorder or incapacity may be asked for it is not a requirement of the scheme. We welcome views on whether, in the absence of the claimant's consent, incapacity should be established before appointment. It is envisaged that consent

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[14] See The National Savings Bank Regulations 1972, S.I. 1972, No. 764, reg. 7(4) which states that where there is no receiver the Director of Savings may, if it is proved to his satisfaction that it is just and expedient to do so, pay the deposits (or a part) to any person whom he judges proper to receive it.

[15] See e.g. *Patient's Money: Accumulation of Balances in Long-Stay Hospitals*, DHSS, 1981. In March 1991 there was a total of £65 million in such accounts (see Select Committee on the Parliamentary Commissioner for Administration: Report of the Health Service Commissioner for 1990-1991, HCP 44, p. 95).

[16] i.e. under the Social Security Act 1986.

[17] Social Security (Claims and Payments) Regulations 1987, S.I. 1987, No. 1968, reg. 33.

[18] DSS Income Support Manual HMSO 1988, para. 2.

would need to be independently established and that both the claimant and the proposed appointee be interviewed before appointment. We therefore provisionally propose:

1. **Unless it is established that a claimant is incapacitated, no appointment under the Social Security Regulations should be made without that claimant's consent.**

5.8 It is usually relatives who are appointed if the claimant lives in the community, the hospital administrator if he or she resides in hospital and the manager of the residential home if he or she is resident in such a home. Once appointed, the appointee receives the claimant's benefits which must then be used in "the best interests of the claimant". Appointees are not subject to any regular checks on how the money is spent although the Department can revoke the appointment if it becomes aware of any improper dealings. One simple safeguard which could be introduced into this system would be to limit appointment to a specified period of say six or twelve months, and require that all those who take on the duties of an appointee agree to account for monies spent on behalf of the claimant if asked to do so. At the end of that period either a fresh application would need to be submitted (requiring ascertainment of either consent or incapacity) or an existing appointee could be reappointed on the basis of satisfactory past performance. It is envisaged that reappointment might involve a supplementary interview with the claimant, consideration of how benefits have been spent in the past, and whether another more suitable appointee exists. For example, a change in appointees may be desirable if a conflict of interest is seen to have arisen between the existing appointee and the claimant. We therefore propose that:

2. **An appointee should be required in every case to agree to provide, if asked to do so, an account to the authorising Department as to how the claimant's benefits have been spent.**

3. **An appointment should expire after a period of [six or] twelve months unless the Department is satisfied on the basis of a previous appointee's past performance that it would be proper for the appointment to be renewed for a further [six or] twelve month period.**

5.9 Regulations which came into force in August 1988 require that the person registered under the Registered Homes Act 1984 must keep a record showing for each individual resident any money either received on his behalf or directly from him and how it has been spent.[19] This provision offers the opportunity through the local social services authority of monitoring those cases where the registered person is the appointee in order to ensure that any benefits received are being used in the interest of intended beneficiaries.[20] Other suggestions which concern monitoring monies belonging to long-term patients and residents are discussed below.[21]

5.10 We understand that many local authorities are reluctant to act as Receiver themselves because of the resource implications.[22] Further, that local authorities often advise that the Public Trustee should act as Receiver[23] in preference to the person registered with the local authority under the 1984 Act.[24] This arrangement, which results in a public office acting as a posting box for social security benefits, seems unsatisfactory not least because it may involve payment of the Public Trustee's fee.[25] Where there is no other person willing or able to act as appointee it is hard to see how the practice of either appointing a residential or

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19 The Residential Care Homes (Amendment) Regulations 1988, S.I. 1988, No.1192.

20 There is no provision requiring a proprietor acting as appointee to ensure that a resident gets his or her personal allowance (the amount of Income Support specified for personal items). It has been suggested that personal allowances frequently get absorbed in home fees when there are insufficient funds to make up the shortfall between the amount charged and the level of benefit received. The legality of this practice may be questioned.

21 See below, para. 5.14 - 5.18.

22 In 1990 local authorities were Receivers in 8.3% of all cases. Macfarlane (1991) *op. cit.*, p. 31.

23 At the end of 1991 the Public Trustee Office was directly managing the estates of 2,573 people: Judicial Statistics (1991) Table 8.6.

24 When residential care budgets are transferred from the social security sector to local authorities the conflict of interest argument sometimes mounted against residential home managers acting as appointees may be used against local authorities acting as Receivers.

25 Court of Protection Rules 1984, S.I. 1984, No.2035, r.82. Although it is also provided that the court may remit or postpone the payment of the whole or part of any fee where in its opinion hardship might otherwise be caused to the patient or his dependants or the circumstances are otherwise exceptional: r.83.

nursing home manager can be brought to an end without causing hardship to those in receipt of benefits. We therefore tend to the view that managers of institutions involved in the care of incapacitated persons are not in principle unsuitable persons to act as appointees.

Release of periodic payments

5.11 As stated above, a number of statutory schemes exist whereby periodic payments by or under the control of a government department may be paid directly to the institution or person caring for an incapacitated person to be applied for his or her benefit.[26] Other rather anomalous schemes include National Savings Bank deposits;[27] payment of shares, loans and deposits held in Industrial and Provident Societies;[28] and payment of vaccine damages.[29] There may be a case for not only bringing all these various existing statutory schemes into line but also including among those who may exercise such a power, banks, building societies and insurance companies or other "paying bodies".[30] One obvious limitation on extending a discretion to make payments to a carer or dependants in this way would be for the individual account or policy holder to be able to opt out of any such provision while he or she still has capacity. This could be done either when the account was opened or policy incepted, or in writing at any time thereafter.

5.12 We invite views on the following outline. When an application is made to a paying body, whether the application be made by a carer or any other person, that body should establish the incapacity of the account or policy holder before considering whether to release any funds. This may be evidenced by a "certificate of incapacity" which would specifically relate to the type or series of transactions in question and be signed by a doctor and/or solicitor and/or social worker. The paying body might wish to satisfy itself, perhaps by

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[26] See para. 5.6 above.

[27] The National Savings Bank Regulations 1972, S.I. 1972, No. 764, reg. 7(4).

[28] The Industrial and Provident Societies Act 1965, s.26.

[29] i.e. under the Vaccine Damage Payments Act 1979.

[30] Other paying bodies might include the Inland Revenue, for example, where overpayment of income tax had occurred.

interview, as to the suitability of the person proposed to receive the money and the extent of the withdrawals or payment needed. A document expressing intention as between the institution and the proposer could be an additional safeguard. It is envisaged for example, that the recipient would undertake to use the money in accordance with best interests criteria provided for the guidance of carers. For larger sums the paying body could require production of invoices, estimates or receipts before releasing any of the incapacitated person's funds. We would welcome comment on the type of institution which might be covered by such a scheme and on the kinds of payments which might be included. Banks and building societies holding funds (including interest) belonging to an incapacitated person are obvious examples. There may be a case for covering monies payable under life insurance policies, including personal pension plans, and even extending the scheme to dividends from unit trusts, personal equity plans and the like. We would also welcome comment on whether there should be a maximum sum (either on a monthly or percentage basis) beyond which no payment should be allowed.

5.13 It is further suggested that a paying body could suspend or terminate the scheme at any time either on receipt of an objection from the account or policy holder or on receipt of any information which suggested that the arrangement was being abused. It is not proposed that the paying body would be liable for misappropriation of money by those named to receive payments under the scheme. Hence we provisionally propose:

4. Institutions such as banks, building societies, and insurance companies, should be able, at their own discretion, to permit a named individual to withdraw money or receive payment from an account or under an insurance policy belonging to an incapacitated person.

5. The institution in question should incur no liability for money withdrawn or received provided that:

(a) the client or policyholder had not opted out of the scheme,

(b) an approved "certificate of incapacity" has been lodged, and

(c) **the proposed recipient has given an undertaking to use the money in accordance with the statutory duties of a carer.**

6. If the client or policyholder or any other person notifies the institution in writing that there are reasons why the scheme should not be continued the institution should suspend or terminate all withdrawals or payments pending further investigation or order of the court.

Personal Allowances

5.14 Many patients in long term care because of their incapacity will not have sufficient contribution records to entitle them to national insurance benefits.[31] However, they may be entitled to a personal allowance if they are residents in a National Health Service hospital. This is provided by the Secretary of State who may pay to persons who are receiving treatment as in-patients (whether liable to be detained or not) in special or other hospitals such amounts as he thinks fit in respect of their occasional personal expenses, where it appears that they would otherwise be without resources to meet those expenses.[32] In practice, however, payments under this section are limited to patients who were admitted to hospital before 17 November 1975. Patients after that date will be supported by the Department of Social Security if they come within the appropriate eligibility criteria for Severe Disablement Allowance.[33] After 52 weeks in hospital the benefit is paid at the same rate of personal requirement allowance as the contributory benefits.[34]

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31 Under the existing rules all patients who have sufficient national insurance contributions will receive their full amount of benefit until they have been in hospital for six weeks. Thereafter benefit is reduced. Finally after 52 weeks in hospital (by which time it is assumed that patients are unlikely to need funds for commitments outside hospital) benefit is reduced to a Personal Requirements Allowance. The rate in 1992/1993 is £10.85 weekly.

32 Mental Health Act 1983, s.122(1).

33 For those who entered hospital after 17/11/75 a non-contributory invalidity pension (NCIP) was paid to men under 65 and women under 60 if they were unable to work for 28 consecutive weeks and did not qualify for contributory benefits. NCIP brought many incapacitated patients into state provision who previously had to rely on "pocket money" at the discretion of the hospital. NCIP has now been replaced by Severe Disablement Allowance (as introduced by Health and Social Security Act 1984).

34 Severe Disablement Allowance (SDA) is the only non-means tested benefit for people who are incapable of work and who have insufficient national insurance contributions to qualify for Sickness and Invalidity Benefit. To qualify for SDA a person must satisfy the 80% disablement test.

5.15 Social security law provides that long stay hospital patients (as opposed to those in residential homes) who have the hospital authorities as appointee can have their benefits reduced or withdrawn on the opinion of the doctor treating them. If the doctor feels that a patient cannot make use of his money then the Department can stop the benefit completely.[35] For those in receipt of benefits covered by the Hospital In-Patient Regulations (which includes Invalidity Benefit, Retirement Pension and Severe Disablement Allowance) there is no right of appeal against the medical officer's opinion. The Department has no discretion once the consultant has made a decision and must reduce or withdraw benefit if that is recommended. Similar provisions apply to those in receipt of Income Support, but the Department need only have regard to the opinion of the hospital authorities and the final decision on withdrawal of benefit rests with the Department. A patient has a right of appeal should he or she disagree. However, as in practice the adjudication officer relies upon the consultant's opinion it seems likely that an appeal would have little chance of success. In summary, while the law confers a right to certain benefits a claimant's (or carer's) access to those benefits may be limited where the claimant is a long-term hospital patient and the hospital authority is acting as a social security appointee.

5.16 There are a number of criticisms of the above scheme some of which may equally apply where the appointee is a manager of a large residential or nursing home.[36] First, there is concern that many of those eligible for social security benefits do not apply for them or have them applied for by the hospital or other authority acting as appointee. For example, the Crosby Report considered that hospital authorities should apply for all benefits to which the patient might be entitled and should adopt an active policy in applying such income for the patients' benefit.[37] This is because those responsible for applying often felt that to spend

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[35] Regulation 16 of the Social Security (Hospital In-Patients) Regulations 1975 provides that the amount that the patient is given can be reduced or extinguished altogether. This will happen where: (i) the patient is incapable of acting for himself and his benefit is being paid to the hospital authorities on his behalf and; (ii) where the medical officer who is treating the in-patient who has received continuous treatment for 52 weeks or longer issues a written certificate to certify that the patient, because of his medical condition, cannot use the money for his "personal comfort or enjoyment".

[36] *Report of the Working Party on Incapax Patients' Funds* (1985) (the "Crosby" Report) noted that the right of patients to handle their own money where appropriate is an important part of rehabilitation and helps to maintain patients' dignity and self respect (para. 57).

[37] *Ibid.*, para. 18.

money on certain patients would be to waste it and consequently no great effort was made to acquire it.

5.17 Another cause for concern arises from the accumulation of monies which are never spent. It could be argued that the putting aside of money for future purposes or for use following a patient's discharge into the community is acceptable but not when its accumulation due to a lack of imagination and lethargy on the part of those responsible for administering the funds.[38] We consider that patients should be encouraged to spend each week their full personal allowance apart from any amount they wish to set aside for purposeful saving. The patient should be free to decide the purposes for which the money is to be used unless on therapeutic grounds it is necessary to prevent any particular type of purchase (for example, alcohol), or unless the patient is so severely incapacitated that he or she needs assistance in making a choice or is unable to exercise choice at all.

5.18 We therefore welcome comment on whether guidance is required for the benefit of all institutional appointees (whether they be hospital authorities or managers of residential or nursing homes) about the discharge of their duties with respect to monies held by them on behalf of incapacitated people.[39] We provisionally propose that:

7. Guidance on the duties of institutional appointees might include:

(a) that claimants should receive all benefits to which they are entitled with written reasons given if any entitlement is not being claimed;

(b) that appointees be subjected to spot checks by Department inspectors, especially where that person or body is acting as an appointee for many patients or residents;

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[38] Department of Social Security guidance is set out in HM(71)90 which gives advice on how hospitals can utilise patients' money. See also, D. Carson, *Making the Most of the Court of Protection* (1987).

[39] For example, it is claimed that sometimes patients' funds are being used to buy items that the NHS should provide free of charge. The Crosby Report and the Mental Welfare Commission for Scotland have drawn attention to misuses of patients' funds in this way. The Crosby Report recommended that proper accounting procedures should be set up: *op.cit.*, para. 113.

(c) **that written records, open to inspection, should be kept as to the sums spent and details of how the money is utilised;**

(d) **that in the case of long-term patients (or long-term nursing or residential home residents), a Review Team should be appointed which would: (i) carry out a regular review of individual patients or residents, their incomes and balances, with a view to encouraging optimal use of funds by staff;[40] (ii) consider hospital cases where it is proposed that allowances should be reduced and review cases where this should be done;[41] and (iii) decide whether the management by the hospital or home of the affairs of individual patients continues to be necessary.**

8. **Claimants should have a right to complain to an independent tribunal[42] if they cannot gain access to their benefit or feel that it is not being spent on them. Further, if a person is incapable of complaining, a relative or friend should be permitted to do so on his or her behalf.**

The authority of a carer or other person to use income or resources on behalf of the incapacitated person

5.19 In Part II of this Paper we proposed that a new statutory authority be given to carers. We envisaged a carer to be someone who had care of an individual who was or was reasonably believed to be incapacitated. The authority conferred was that of doing what was "reasonable in all the circumstances" to care for that person so long as it was consistent with

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40 The Crosby Report *op.cit.*, outlines a list of suggested categories of expenditure. See paras. 69 - 88 and Appendix V.

41 See the Crosby Report, *op.cit.*, para. 110.

42 Responsibility for the organisation and administration of tribunals is vested in the Independent Tribunals Service (I.T.S.) (formerly the Office of the President of the Social Security Appeal Tribunals). ITS is independent of the Department of Social Security and currently runs a system of tribunals covering: social security appeals, medical appeals, disability appeals, child support and vaccine damage appeals. Of these Social Security Appeal Tribunals would probably by the most appropriate.

what was in that person's best interests.[43] The effect of this provision would be to legitimise a wide range of activities which are undertaken by carers every day.

5.20 At present it seems likely that many carers do undertake substitute decision-making with respect to financial matters and that any statutory authority which excludes such responsibility is unrealistic. For example, carers may buy the weekly shopping and pay routine bills with money belonging to the person for whom they are caring. We would welcome comment on whether the limit to the carer's authority should exclude all financial decision-making or whether a carer should be authorised (perhaps after a consultation process which included any appointee or attorney or financial or personal manager who had been appointed[44]) to spend the client's income on a day-to-day basis according to the criteria proposed with respect to personal care and welfare.

5.21 However, even if the authority of a carer, as opposed to an administratively authorised "receiver", was not extended to include financial decision-making we take the view that those who are authorised to receive money on behalf of an incapacitated person should be subject to the "best interests" criterion proposed in relation to personal care. We therefore provisionally propose that:

9. Where [a carer or] other person is the authorised recipient of payments due to an incapacitated person he or she may do what is reasonable in all the circumstances with regard to those payments.

10. Such a person must act in the best interests of the incapacitated person, taking into account:

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

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[43] See para. 2.13 above.

[44] For the appointment of a financial manager see further para. 5.24 *et seq*. For the appointment of a personal manager see further Part VI.

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

Delimiting financial decision-making powers

5.22 There are certain actions which would in our view fall outside any general authority of the type proposed. These include all those contractual situations in which the person's own authority, rather than that of a substitute decision-maker, would normally be sought by an interested (rather than an unscrupulous) third party.[45]

5.23 Neither a carer nor an informal "receiver" will have any document which evidences his or her authority to contract on behalf of an incapacitated person. For this reason it will be difficult for carers to persuade third parties to enter into transactions with them or accept instructions which purport to be made on behalf of the person being cared for.[46] An exception may arise in the purchase of necessaries[47] or where the nature of the transaction is otherwise uncontroversial, for example because the person being cared for has the capacity to appoint an agent to act on his or her behalf.[48] However, in the majority of cases the carer's authority will effectively be restricted by the lack of any express written authority to

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[45] If the person being cared for has not consented it is likely that the carer will be liable for either the tort of trespass to goods or conversion. See further para. 2.5 above.

[46] This problem would not arise if the carer was also an attorney either acting under an ordinary power of attorney (if the donor had capacity) or under an enduring power of attorney (if the donor had lost capacity): see further Part VII.

[47] The Sale of Goods Act 1979, s. 3(2), which provides that a reasonable price must be paid for necessaries which are sold and delivered to a person who by reason of mental incapacity is incompetent to contract, only applies if the contract could not be enforced i.e. because the supplier **knew** that the person was under a mental incapacity. Cf. the position of a supplier who did not know the person was under a disability and may therefore recover the contract price.

[48] However, if the third party believes that the carer is acting in a way which goes beyond what the person cared for is able to do for himself, e.g. because of incapacity, the third party may well question the carer's authority. It is likely that much will depend on the value of the transaction and the seriousness of the decision to be made.

contract on behalf of the person cared for. We tend towards the view that those who care for incapacitated adults should not be given authority to enter into contractual relations on behalf of an incapacitated adult. However, as stated above we do propose that in certain circumstances a carer or other appointed person may have access to an incapacitated person's income and capital.[49] It may be considered anomalous not to extend a similar limited authority to enable a carer to sell chattels. For example, a carer might need to sell a chattel belonging to the person being cared for in order to raise a sum of money for the reasonable purpose of mending a leaking roof in that person's home. Although we consider that a financial limit should be placed on any such transaction it is not clear what ceiling should be applied. For example, a limit of £500 may constitute the whole life savings of some individuals yet be a modest amount to a wealthier client. Consideration would also need to be given to whether the limit should apply per item or over a stated period of time. Having the limit expressed in percentage terms of capital may be the fairest method but would make it virtually impossible for third parties to assess whether it was a valid transaction or not. A fixed price limit would solve this problem. We are of the view that in each case the duties applicable to a carer with respect to the use of authorised payments from the paying bodies described above should apply.[50] We therefore provisionally propose that:

11. A carer has no authority to enter into contractual relations on behalf of an incapacitated person or to sell or otherwise dispose of that person's property other than with respect to the sale of a chattel where the proceeds do not exceed [£100].

12. Where a carer sells or otherwise disposes of a chattel belonging to an incapacitated person he or she must exercise the same duties with respect to that sale or disposal as a carer or other person who receives any other payment due or belonging to that person.

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[49] See paras. 5.6 - 5.18 above.

[50] Although the duty includes acting in the best interests of the incapacitated person the preservation of interests in property with regard to rights of succession may not be possible if the chattel was the subject of a gift taking effect on the incapacitated person's death and he or she has lost testamentary capacity. Cf. Mental Health Act 1983, s.101.

5.24 As stated in our consultation paper, triggering intervention by the Court of Protection has the effect of suspending an incapacitated person's ability to act for himself or herself in all areas within the court's jurisdiction, even if he or she has the capacity to do so in some respects, or from time to time.[51] It has been suggested that this "all or nothing" approach does little to enhance the autonomy of individuals who are still capable of managing some of their financial affairs and who otherwise remain self-determining.[52] However, where people are totally incapacitated (perhaps from birth) and their estates need continuing supervision, setting up and running complex management procedures may be a necessary protection.[53] Where a Receiver has been appointed without limit of time the methods by which the Court of Protection must control his or her activities are burdensome and expensive and must be paid for by the client. We consider below whether a better balance between protection and client autonomy might be achieved by the use of single issue orders and the appointment of Court supervised financial managers who could act either indefinitely or for only a limited period of time.

5.25 At present before a Receiver is appointed the Court of Protection will usually write to the person concerned explaining why the application has been made, by whom, and what steps are proposed.[54] The person concerned may object to the proposals which have been made.[55] Relatives and other interested parties should also be notified of the application although evidence of such notification is not usually required.[56] Although a date for

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51 Consultation Paper No.119, para. 3.7.

52 While there is a danger that a difficult decision may be postponed or avoided while the "right moment" to take instructions from the incapacitated person is awaited, a legal framework which positively promotes "normalisation" was largely supported by those who responded to our consultation paper.

53 It was to cater for this type of circumstance that the Court of Protection developed its jurisdiction.

54 The letter is treated as a formal notice and it is the practice of the Court to require that it be given to the patient personally. However, the Court may, inter alia, dispense with notification if there is medical evidence that notification would be injurious to the patient's health or he would be incapable of understanding it: see Court of Protection Rules 1984, S.I. 1984, No. 2035, r.23.

55 *Ibid.*, r.24.

56 *Ibid.*, r.18(4).

consideration of the application will be notified, the matter is dealt with on the papers unless there is a dispute, and a "First General Order" issued.[57] The first general order usually authorises the Receiver to collect all income rightfully due to the patient and may also authorise the Receiver to carry out or execute any other acts which at that time are necessary in the best interests of the patient's financial affairs. Authority to sell property, settle debts and receive capital are often included in the first general order. During the life of the receivership other applications may be made to the Court, for example, to authorise the making of settlements, gifts or the execution of a statutory will on behalf of an incapacitated person.

5.26 We tend to take the view that where a general authority is needed to put an incapacitated person's affairs in order or to oversee a period of transition from one level of care to another it would be appropriate to appoint a financial manager but usually only for a limited period of time. The issue of a general order would not disbar either the financial manager or any other applicant (including the incapacitated person) from applying for a single issue order[58] during the currency of the management period. However, it is anticipated that the proposed financial manager would normally draw up a plan detailing the proposed course of action and investment policy to be pursued during the period of his or her management. In some cases of permanent incapacity, an indefinite appointment might be required but in such cases it would be desirable to provide for regular reviews.

5.27 As with the present procedure on appointing a Receiver it is suggested that the incapacitated person be notified of the proposed order and be given an opportunity to object to any of the proposals it contained. Consultation should also take place with other interested parties, for example, a carer, any authorised receiver of benefits or other payments due or belonging to the client and any personal manager.[59] If there was any contention a hearing might be appropriate or alternatively the court might make its own investigations. It is

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[57] The order may specify that the Receiver is to be the holder for the time being of a specified office e.g. the Director of Social Services.

[58] See further paras. 5.29 *et seq.*

[59] For the appointment of personal managers see Part VI.

envisaged that authority to manage would lapse after a stated period of either six or twelve months. Renewal would be subject to the satisfactory past performance of the financial manager and a personal visit (perhaps by one of the Lord Chancellor's visitors or other nominated person) to establish the views of the incapacitated person and to monitor any change in circumstance which might have arisen. As stated in Part IV the Court should be directed in every case to make an order which is in the best interests of the incapacitated person, applying the guidance as to "best interests" already suggested in relation to carers and administrative level "receivers".

5.28 If appointments are limited in duration and orders dealing with any specific issues of financial management which might arise (whether or not a financial manager has been appointed) are available, the present level of control over Receivers by the Court of Protection may not be necessary. Accordingly we take the view that the Court should have to give specific consideration to whether a financial manager should be required to give financial undertakings or produce annual accounts. Similarly, the extent to which a particular financial manager might exercise his or her own discretion as to how the client's affairs are managed, for example, with regard to investments, should be considered in every case. We provisionally propose that:

13. The Court may grant a general order to a named financial manager to act on behalf of an incapacitated person.

14. The order may include authority to: take and grant a lease; sell or purchase property; make repairs or improvements to property belonging to the client; sell furniture and effects; receive all income due to the client; resort to capital for the purpose of maintaining the client; make gifts out of the client's surplus income to reflect the relevant tax exempt limit and make non-monetary gifts to the same value; make investment in or sale from equities or other investment policies on the advice of an investment manager approved by the Court.

15. Appointments should be made in the first instance for a period of [six or] twelve months but may be renewed for periods of [six or] twelve months at a time.

16. When appointing a financial manager the Court should give consideration to both the level of accounting and security required of that manager and the scope of his or her powers to invest (as well as receive) money due to or belonging to an incapacitated person.

Single issue orders

5.29 In Part IV we proposed that as a general principle it is preferable that an order dealing with a specific issue be made rather than an order appointing a manager with continuing powers of substitute decision-making. At present the Court of Protection can be approached for a "Short Procedure Order" to allow a named person to deal with small amounts without a Receiver being appointed.[60] However, this can only be done when the incapacitated person's assets do not exceed £5,000.[61] An exception is when the Court considers the appointment of a Receiver unnecessary.[62] The Court of Protection adopts a restrictive interpretation of its discretionary powers in this respect.[63] As a result the limitation on the use of short procedure orders means that unless there is a valid enduring power of attorney the majority of cases brought to the Court's attention will be, or result in, applications for receivership.[64]

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[60] Application for a "Short Procedure Order" is done by bringing the facts to the attention of the court, preferably using the form provided by the Public Trust Office, together with medical evidence showing that the patient is suffering from mental disorder and cannot manage for himself. Proposals for how the money should be dealt with may also be included for consideration by the Court.

[61] Court of Protection Rules 1984, r.7(1)(a).

[62] *Ibid.*, r.7(1)(b).

[63] According to Heywood & Massey, a "short procedure" order is frequently used when a patient becomes entitled to a small share in an estate, the usual provision being to direct investment of the amount due to the patient and payment thereout of regular sums for extra comforts, see *Court of Protection Practice* (12th ed., 1991) p. 5.

[64] According to statistics provided by the present Master a Short Procedure Order was made in 9.2% of cases in 1991. Macfarlane (1991) *op. cit.*, p. 30.

5.30 We tend towards the view that the financial limit on the use of short procedure orders should be removed to enable the use of single issue orders to be developed. The present rule states that an officer of the court or some other suitable person named in the order may be directed to deal with the patient's property (or any part of it) or with his or her financial affairs in any manner authorised by the Mental Health Act 1983.[65] Accordingly (excepting the financial limit), there is no reason why a single order may not be granted which would authorise an applicant to deal with any specific issue covered by the powers[66] available to the Court under its Mental Health Act jurisdiction.

5.31 We consider that an application for a single issue order could be made regardless of whether an appointee or other informal "receiver" has been appointed. Such orders are in effect available at present although they are only available after a Receiver has been appointed by the Court of Protection and then only on his or her application.[67] The use of single issue orders would have the effect of reducing the need for resort to plenary powers. We therefore provisionally propose that:

17. The financial limit with regard to the jurisdiction of the Court of Protection where no Receiver has been appointed should be removed and the use of single issue orders should be encouraged.

5.32 Although it is envisaged that the majority of applications in the new jurisdiction may be dealt with by the use of single issue orders more intensive financial management may be necessary for some periods. For example, where a client's mental health is deteriorating due to old age or senility money may be misappropriated if protection is not increased. Alternatively, the person concerned may have become entitled to a lump sum[68] which needs proper investment and management if it is to provide income for the incapacitated person at

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[65] See the Court of Protection Rules 1984, r.7(2).

[66] For a list of the relevant powers see Mental Health Act 1983, s.96(1)(a) - (k).

[67] Once a Receiver has been appointed he or she takes over control of all the client's property and affairs including receipt of social security benefits and any other income due to the incapacitated person.

[68] This may be because the person has been left money in a will or has been awarded damages.

the same time as providing an opportunity for improvement in the level of care and support provided. One solution to the need for increased management and supervision we have proposed is for a financial manager to be appointed for a limited period of time. However, in some cases the client may have sufficient capacity to choose a manager for themselves. At present the Court of Protection has no power to appoint an attorney for people who are incapable of managing their own property and affairs under the Mental Health Act 1983 although if there is a dual application, for both the appointment of a Receiver and the registration of an enduring power of attorney, the Court may well prefer the latter. Below we consider whether the Court should be able to direct the appointment of an attorney with enduring powers instead of appointing a financial manager.

Appointment of an attorney

5.33 Under the existing law an enduring power of attorney may avoid the necessity for an application for the appointment of a Receiver if the person executing it is nevertheless able to understand the nature and effect of the power at the time when he or she signs it.[69] Appointment of an attorney by a donor has certain advantages over the appointment of a Receiver by the Court. For example, a donor of an enduring power of attorney does not have to pay annual fees to the Court to cover the costs of supervising and regulating the activities of an attorney. Under the Enduring Powers of Attorney Act 1985 the Court's main function is limited to receiving and considering applications for registration. Following registration the Court does not expect to be further involved beyond giving such supplementary consents and authorisations as are required and requested by the attorney providing that they are not inconsistent with the restrictions imposed by the donor before losing capacity.

5.34 Although the Court of Protection may, inter alia, require an attorney to produce accounts and furnish information to the Court as to his or her activities the exercise of this power is left to the Court's discretion.[70] It can be argued that the extra expense and

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[69] See *Re K., Re F.* [1988] Ch. 310. It appears that the donor's capacity to choose a suitable attorney is not at issue.

[70] See the Enduring Power of Attorney Act 1985, s.8(2). The Court also has power to relieve the attorney from any liability which he may have incurred on account of a breach of duty: s.8(2)(f).

burdensome nature of receivership is not justified merely because a person is incapable of choosing their own financial manager (or maybe simply fails to exercise what capacity to choose he or she has). The proposals made earlier for changing the relationship between managers and the Court might go some way to answering this. Some commentators have suggested that the barriers between receivership and enduring powers of attorney may have been "too tightly drawn" and more flexibility between the two should be introduced.[71] Therefore while we acknowledge the conceptual difference between the two schemes we think there is some force in the argument that there are benefits in "switching jurisdictions" and we would welcome comment on this. One option would be to restrict the Court to giving a direction that the donor has sufficient capacity to appoint an attorney rather than allowing the court to make the appointment itself. Such a direction might relate to a recent or virtually contemporaneous appointment or to the person's capacity to make one within a defined period of time. It is envisaged that this would not prevent the Court from involvement in overseeing the execution of the power. This option might enable a financial manager to become an attorney either during or after a limited period of management. We therefore provisionally propose that:

18. The Court may direct that a client has capacity to execute an enduring power of attorney within a specified time and may oversee the appointment of a suitable attorney.

Establishing a court-imposed trust

5.35 A few of those who responded to our consultation paper were in favour of trusts as a means for managing the property and affairs of incapacitated adults. However, a number of disadvantages are thought to exist in connection with trusts.[72] These include management fees and other expenses eating into any income received (this may not be a problem if the amounts involved are quite large e.g. over £75,000); the difficulty of finding trustees who are both competent and impartial; and the problem of drafting the deed so as to reconcile

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[71] G. Ashton and A. Ward, *Mental Handicap and the Law* (1992), p. 578.

[72] i.e. set up under a deed and approved by the Court.

flexibility with prudence and security.[73] Many of these difficulties may also be said to apply to receivership. The main distinction, however, is that while in the case of receivership the funds remain vested in the incapacitated person, in the case of a trust the funds are held by the trustees.[74]

5.36 In their Discussion Paper[75] the Scottish Law Commission propose the establishment of an administrative trust[76] by which the income and, if necessary, the capital of a mentally incapacitated person's estate may be applied, inter alia, for his or her own maintenance and benefit. The trustee or trustees would be appointed by a court or other appointing body and may include a member of the mentally incapacitated person's family as well as someone with a degree of expertise in financial affairs.[77] The purposes of the trust and powers of trustees would be defined by statute or subordinate legislation although it is anticipated that modifications and/or additions may be authorised where appropriate.

5.37 Many of the difficulties anticipated by the Scottish model apply in England and Wales. These include the resignation and appointment of new statutory trustees, the need for guarantees by and remuneration of trustees, the tax and social security benefit implications for the beneficiary and dealing with powers of accumulation and investment. Advantages are perceived to be the close personal knowledge brought to bear by a family member acting as trustee, the avoidance of "the intrusion of public officials" into "private matters" and the saving of fees paid to the Accountant of Court (the nearest Scottish equivalent to the Public Trustee). The Scottish Law Commission acknowledges that the proposed trusts are bound to be more expensive than financial management by a lay manager[78] and this may be the reason why it is not common for the Court of Protection to make settlements. We tend to take the

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[73] See Supreme Court Practice 1992, Jacob (ed), vol 1, pp. 1297-8.

[74] In relation to the vesting of funds the attorney's position is the same as that of a receiver.

[75] Discussion Paper No. 94. *op. cit.*,

[76] *Ibid.*, proposal 52.

[77] It is suggested that a professional trustee service may be an appropriate second trustee in such cases: *ibid* para. 4.144.

[78] *Ibid.*, para. 4.149.

view that the advantages outlined above in connection with any introduction of a statutory trust are outweighed by the disadvantages. Further, that many of the benefits such a scheme might confer may be more effectively achieved by the flexible use of single issue orders, limited periods of plenary substitute financial management and, where possible, encouragement and support for clients able to determine how they would like their property and affairs managed and by whom.

PART VI

DECISIONS ABOUT PERSONAL CARE AND WELFARE

Introduction

6.1 We deal in this part with detailed proposals for a new scheme for dealing with decisions about personal care and welfare.[1] It may be helpful to list at this stage the range of decisions covered by such schemes elsewhere:[2]

(1) Where to live
(2) Whom to live with
(3) Whom to see and not to see
(4) Which social activities to have
(5) Whether to work, where and what as
(6) Whether to have education or training
(7) Whether to consent to medical treatment[3]
(8) Day to day decisions about diet and dress
(9) Reading personal correspondence and papers
(10) Exercising rights to personal information[4]
(11) Applying for housing, social services and other benefits[5]
(12) Whether to leave the country

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1 We deal in Part VII with advance delegation of personal decisions by an extension of the scheme for enduring powers of attorney.

2 The list is largely derived from the list of "guardianship powers" set out in Alberta's Dependent Adults Act 1976 (as amended) s.10(2).

3 This issue will be dealt with separately.

4 Such as those under the Data Protection Act 1984, the Local Government (Access to Information) Act 1985, the Access to Personal Files Act 1987, the Access to Medical Reports Act 1988 and the Access to Health Records Act 1990. The latter is the only one of these recent statutes to mention those who do not have the capacity to exercise the rights granted (by providing that a court appointed manager, i.e. a Receiver, can exercise the rights on another's behalf). For a fuller discussion see G. Ashton and A. Ward, *Mental Handicap and the Law*, (1992) pp. 141-146.

5 Mental incapacity in applicants under the Housing Act 1985 was considered in *R* v. *Tower Hamlets London Borough Council, exp. Lutfur Rahman* and *R* v. *Same, exp. Ferdous Begum*, [1993] 2 W.L.R. 9. An appeal to the House of Lords is pending.

6.2 Guardians (under the Mental Health Act) can be authorised to take a selected few of these decisions. For others, there is no provision in English law whereby a "substitute" can take them on behalf of an incapacitated person. Statistics from the Guardianship and Administration Board of Victoria indicate that the majority of orders made by the Board deal with the two specific issues of residence and medical treatment.[6] The main difficulty or dispute which the proposals in this Part set out to resolve is likely to be that of the best place of residence for an incapacitated person.

6.3 There are a number of "personal" decisions which fall into a different category, in that the law already provides or assumes that they must be taken personally. These include:

(1) Whether and whom to marry, or consent to divorce
(2) Whether to consent to an adoption of a child
(3) Whether and with whom to have sexual relations
(4) Whether to vote and in what way[7]

It may be necessary to clarify the types of decision which may be made in accordance with any new procedure, in order to ensure that this is consistent with existing provisions.

The need for judicial orders

6.4 We have already proposed in Part II that carers have a general authority to take reasonable steps in the care of an incapacitated person, with a duty to exercise this in that person's best interests. "Best interests" will require taking into account the person's wishes, the least restrictive option and encouraging the person to take as many decisions as possible. We have also proposed that this authority should not include confinement, or actions with

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[6] 51% of personal guardianship orders limit the guardian to substitute residence and health care decisions; a further 20% limit the guardian to health care decisions only (T. Carney and D. Tait, *op.cit.*, p.iii.).

[7] The procedures for postal and proxy voting do not provide for mental incapacity on the part of the principal voter, nor require any declaration as to capacity.

which the incapacitated person actively disagrees. Furthermore, in some of the areas listed above, third parties will limit the extent to which a carer can act on behalf of an incapacitated person. Forms or documents may have to be signed, perhaps with some declaration as to understanding. It may not be possible for a carer to arrange a change of residence if those in charge of the new residence need contractual formalities to be complied with. Other than these, however, we tend to think that there is no need for further express restriction of the carer's authority.

6.5 There may, therefore, be a need for outside determination of an issue in circumstances such as the following:

(1) It is unclear or disputed whether or not the person is incapacitated.

(2) The incapacitated person actively objects to a decision taken by the carer or another person about his personal care and welfare.

(3) The carer wishes to use confining measures.

(4) There is a dispute between the carer and some other interested person (including the incapacitated person) about a particular matter.

(5) A third party requires an authorised substitute decision of the incapacitated person (either because there is no carer or the third party will not accept the informal authority of the carer).

6.6 In practice, many of these problems can be resolved without any sort of judicial determination. Almost all issues of any importance will be concerned in some way with the provision of health or social services for the person concerned. The level of social services involvement in decisions about residence and other activities and services for incapacitated people will increase once the National Health Service and Community Care Act 1990 is fully in force. If there are disagreements between professionals, or between family and carers and professionals, these can usually be resolved by negotiation and agreement using established informal consultation and case conference procedures.[8] These should obviously be

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[8] *Community Care in the Next Decade and Beyond: Policy Guidance* (1990) sets out policy for "care management" which should include "design of a 'care package' in agreement with users, carers and relevant agencies" and monitoring and review by a "care manager" not involved in direct service provision (paras. 3.9 and 3.10).

encouraged whenever possible and there may be no need to place them on a more formal footing. We would welcome views on this.

6.7 If an incapacitated person objects to the community care arrangements that have been negotiated or agreed on his or her behalf, formal or coercive measures may be required, but this would be a matter of public, rather than private law, and we shall consider this elsewhere. Disputes between private individuals in relation to matters of personal care are likely to be extremely rare. They should only arise for judicial determination if there is a real dispute as to fact, law or both. The general principles which might govern such a jurisdiction have already been discussed in Part IV. It remains to discuss what range of orders should be available, who should be able to apply, and the qualifications, powers and duties of a personal manager who might be appointed.

A range of orders

6.8 We have already proposed that there should be power either to resolve a particular issue or to appoint someone to manage the personal care and welfare of the incapacitated person. In accordance with the principle of "least restrictive option", we have also proposed that the judicial authority seek first to deal with the specific issue before it. The appointment of a continuing "personal manager" should be a secondary option. The Children Act 1989 lists four sorts of "private law" order which can be made by a court: a contact order, a prohibited steps order, a residence order and a specific issue order.[9] It also provides for the

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[9] Children Act 1989, s.8(1):

> "'a contact order' means an order requiring the person with whom a child lives, or is to live, to allow the child to visit or stay with the person named in the order, or for that person and the child otherwise to have contact with each other;
>
> 'a prohibited steps order' means an order that no step which could be taken by a parent in meeting his parental responsibility for a child, and which is of a kind specified in the order, shall be taken by any person without the consent of the court;
>
> 'a residence order' means an order settling the arrangements to be made as to the person with whom a child is to live; and
>
> 'a specific issue order' means an order giving directions for the purpose of determining a specific question which has arisen, or which may arise, in connection with any aspect of parental responsibility for a child."

appointment of guardians.[10] This could be a useful model, suitably adapted,[11] for a range of powers relating to incapacitated people.

6.9 New Zealand's legislation in this field is unusual in providing for substitute decision-making by court order rather than appointment of a proxy, and lists a series of "personal orders" which the court can make. They can be summarised as follows:

(1) An order for the remuneration of the incapable person for work performed
(2) An order that a parent arrange suitable care for the person after the parent's death
(3) An order varying or confirming the arrangements made by a parent under (2) above
(4) An order that the person go to or leave an institution (not including a mental health facility)
(5) An order that the person be provided with living arrangements
(6) An order that the person be provided with medical advice or treatment
(7) An order that the person be provided with educational or therapeutic services
(8) An order that the person not leave the jurisdiction (or only on conditions)
(9) An order appointing a litigation guardian
(10) An order appointing a financial administrator
(11) An order appointing a welfare guardian[12]

6.10 The Act stipulates[13] that no order binds anyone who is not a party to its making. It will also be noted that orders (2) and (3) specifically permit parents to make arrangements for an adult child in the event of their death. This contrasts with the policy of the

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[10] *Ibid.*, s.5(1).

[11] Since prohibited steps and specific issues could not be defined in terms of "parental responsibility", a concept which does not exist in relation to incapacitated adults.

[12] Summarised from the Protection of Personal and Property Rights Act 1988, s.10. Consequential orders and directions can also be made (s.10(4)).

[13] *Ibid.*, s.10(2).

Guardianship and Administration Board of Victoria, which will not countenance the making of guardianship orders to cater for future needs.[14]

6.11 It will also be noted that orders (5), (6) and (7) are aimed at enforcing the provision of a particular service for a incapacitated person. As we emphasised in the consultation paper, we are not concerned in this exercise with the level of health and social services which ought to be provided, nor with enforcing the claims of individuals to such services.[15] We are concerned in this paper with providing mechanisms for decision-making where issues arising between individuals cannot be resolved in any other way.[16]

6.12 We anticipate that many of the disputes in the personal care field will be about the place of residence of the incapacitated person. We also anticipate disputes about social contact between the incapacitated person and others, especially where the person lives with relatives who may object to other relatives or friends.[17] There is also a need for orders comparable to injunctions which protect the person from undesired or undesirable interference from another person. There are disputes about other matters which will need to be resolved and we invite comment on how these should be defined, given that there is no concept comparable to "parental responsibility". We therefore provisionally propose that:

1. The judicial authority may make any one or more of the following personal orders:

(i) An order settling the arrangements to be made as to where or with whom an incapacitated person is to live.

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[14] See above, para. 4.11.

[15] Consultation Paper No. 119, para. 1.15.

[16] Issues where a public authority wishes to take action which is resisted either by the person concerned, or by the family or carer, will be considered separately.

[17] *C. v. United Kingdom*, decision of the European Commission of Human Rights of 3 July 1992 (Application No. 14247/88) was on a complaint by a father that he had been denied access to his adult daughter who resided in local authority accommodation. It was noted that there was no right in English law for parents to have access to their adult offspring.

(ii) An order requiring the person with whom the incapacitated person lives to allow that person to visit, stay with or otherwise have contact with another person.

(iii) An order restraining a person from having contact with, molesting or otherwise interfering with the incapacitated person.

(iv) An order dealing with a specific issue in relation to the care or welfare of the incapacitated person.

No such order would bind anyone not a party to its making.

6.13 Only if a specific order cannot resolve the issue should a continuing manager be appointed. In some jurisdictions it is still possible for a "plenary guardian" to be appointed.[18] In Alberta, the concept of plenary guardianship was abolished by an act amending the original legislation.[19] A list of guardianship powers is now set out, so that if the power is not in the court order the guardian will not have it.[20] We think an appointment with specified powers preferable to any reference to "plenary" powers or the powers of a parent over a child, an outdated and anyway notoriously unclear concept (though certainly comprising reasonable chastisement). Only 13% of the guardianship orders made by the Victoria Board were for plenary guardianship.[21] We doubt that there is a need for any "plenary guardianship" order as such, and would propose that the court work from a list, specifying the powers granted. As with financial managers, it is anticipated that the proposed personal manager would normally draw up a plan detailing what was proposed. Although this

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[18] Victoria's Guardianship and Administration Board Act 1986, s.24(1) states that a plenary guardian has "all the powers and duties which the plenary guardian would have if he or she were a parent and the represented person his or her child."

[19] The Dependent Adults Act 1976 s.9 (1) (j) originally provided for plenary guardianship by listing specific powers and then adding a power "to make any other decisions that can be made by a father in respect of a child under 14 years of age..."

[20] Dependent Adults (Amendment) Act 1985, s.11 (1) inserted a new s.10(2) into the 1976 Act. This sets out a list of nine powers, but s.10(2) (j) also refers to "any other matters specified by the Court..."

[21] T. Carney and D.Tait, *op.cit.*, p.48.

might sometimes result in extensive powers being granted, it is better in principle that the order be specific. We therefore provisionally propose that:

2. **If the judicial authority finds that a personal order will not be sufficient to benefit the incapacitated person, it may appoint a continuing personal manager for that person. The manager will have such powers in relation to that person's personal care and welfare as are specified in the order making the appointment.**

6.14 If there is to be no plenary guardianship as such, we doubt the need to preclude the exercise of particular powers by any manager (such as consenting to particular sorts of treatment).[22] The issues involved in medical treatment will be considered separately. However, if a manager is given power to make decisions about residence, it may be desirable to clarify the situation as to detention in hospital. Broadly, we would not propose any alteration to the present practice of informal admission to hospital,[23] provided that the manager's powers are not used to oblige a person to stay in hospital; neither do we intend to displace the detailed provisions of the Mental Health Act 1983 in relation to compulsory admission to and treatment in hospital. We therefore propose that:

3. **Admission to, and detention and treatment in, a hospital or mental nursing home should continue to be governed by the Mental Health Act 1983.**

6.15 There may well be cases where it turns out that the person concerned is not incapacitated, either in general or in relation to a particular matter. In such cases, the judicial authority should have power to make a declaration to that effect. There may also be circumstances in which the judicial authority wishes to make recommendations even when declining to make any order. For example, it might recommend that the person the subject

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22 In New Zealand, no guardian or attorney can take decisions about the marriage, divorce or adoption of children of the principal (as well as certain health care decisions) (Protection of Personal and Property Rights Act 1988, s.18).

23 Mental Health Act 1983, s.131(1).

of the application execute an enduring power of attorney. Even if such recommendations were not binding, they might achieve results which would benefit the client.[24] We therefore welcome views on whether:

4. **The judicial authority may declare that the person concerned is not incapacitated, either in general or in relation to a particular matter.**

5. **The judicial authority may make recommendations instead of making any order.**

Applicants

6.16 Some jurisdictions have placed limitations on categories of applicants (or require some applicants to obtain leave), and our present guardianship system limits access to approved social workers and "nearest relatives". We envisage situations in which carers, relatives, and friends might wish to apply. We also think it important that the client should be able to make an application and this should include someone who is being treated by carers or others as if he or she were incapacitated. It is equally important, however, that only those likely to have a genuine interest in the person's welfare should have the right to seek an order. We anticipate that some applicants should have a right to apply to the court, while others would have to obtain leave. We therefore provisionally propose that:

6. **Close relatives, carers and the person himself or herself, should have a right to apply for an order. Other persons might apply with leave of the court.**

6.17 An important and difficult question is whether health or social services authorities, or individual practitioners, should be able to invoke the proposed new jurisdiction. In principle, they should use the provisions of the public law, which will be considered separately. However, it may be that the distinction between public and private law is not as clear-cut in

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[24] Cf. New Zealand's Protection of Personal and Property Rights Act 1988, s.13.

this area as it is in relation to the upbringing of children, where important issues arise as to the justifications for state intervention in family life. If the issue is whether or not a mentally incapacitated person should be obliged against his or her will to enter a local authority home or otherwise participate in social services activities, then the public law provisions would be more appropriate. But the Children Act 1989 allows anyone, including a local authority or voluntary organisation, to apply, with leave, for a specific issue or prohibited steps order. We would therefore welcome views on the following possible compromise:

7. Health and social services authorities, and individual professionals, should be permitted to seek leave to apply for any order [apart from a residence order].

Personal managers

6.18 In many cases, a close friend or family member will be the obvious choice for appointment as a manager. Some jurisdictions disqualify certain persons from appointment on the basis that they provide services.[25] Victoria and New Zealand both have a general restriction against people whose interests are likely to conflict with those of the client. In view of our proposal that specific guardianship powers be given, and the increasing range of people who will provide services under the community care legislation, we do not favour a blanket prohibition on service providers. We can envisage a situation where a residential home worker would be an appropriate manager for limited personal decisions. We therefore provisionally propose that:

8. The judicial authority may appoint any person who will discharge the duties of a personal manager and whose interests do not conflict with those of the incapacitated person.

6.19 Jurisdictions with special public bodies to represent disabled people have a further choice of guardian. In Victoria, the most recent Annual Report reveals that the Public

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[25] Draft Ontario legislation disqualifies all paid service providers (Substitute Decisions Bill, clause 54(1)).

Advocate was appointed guardian in 72.2% of cases.[26] It seems that the Public Advocate will always be appointed if there is no relative available or suitable, so that only one sort of public employee would ever discharge this role. At present in England, the Public Trustee can be appointed if no other Receiver can act (his fees being charged to the estate of the patient). There may be a need for a similar appointee of last resort in personal matters. The Scottish Law Commission have suggested that named social workers could be appointed to fill any such gap, though acknowledging the possibility of conflict of interest.[27] In the personal care field, it would be desirable that any official appointee have a personal relationship with the incapacitated person. A local authority social worker would be the most likely public employee to fulfil this role. However, we do not think it appropriate that a named social worker should be appointed. The worker should not be expected to act in his or her personal capacity. As a matter of practice, we would expect Social Services Departments to have a policy of naming a responsible social worker and ensuring continuity of involvement with the incapacitated person. However, we tend to the view that the appointment itself should refer to the Director of Social Services for the appropriate local authority. We therefore propose:

9. The judicial authority may appoint the Director of Social Services for the appropriate local authority as personal manager if there is no other suitable candidate.

6.20 We see no objection to joint (or joint and several) managers being appointed, nor to an order appointing one private person and one public employee. Disputes between joint managers would be a good indication of the need for further involvement by an outside body. If disputes arose the matter could be brought back for directions or further order. We do not anticipate many long-term orders and therefore doubt the need for successive or alternate managers to be appointed.[28] We invite comments on a proposal that:

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[26] Victoria Guardianship and Administration Board Annual Report 1990-91, p.29.

[27] Discussion Paper No. 94, para. 2.65.

[28] In a recent Scottish petition for the appointment of tutors-dative an alternate appointment of a younger relative was requested, though a joint appointment of all three relatives was eventually made. See further A. Ward, "Tutors to Adults: Developments", (1992) 33 S.L.T. 325.

10. The judicial authority may appoint joint, joint and several, alternate or successive personal managers.

6.21 In those cases where parents wish to provide a continuing framework of care and supervision for a mentally disabled child, they may seek to transfer any management powers granted to them by testamentary appointment of a substitute. This could be distressing and stigmatising for the incapacitated person and we do not think decision-making powers should be transferred as if the person concerned were still a child. We have proposed that the judicial authority have power to appoint successive managers, and think it better in principle to deal with this situation in that way. If a further application is necessary, the views of deceased managers could be taken into account.

Duration and supervision of appointments

6.22 The "least restrictive option" suggests that all orders should be of limited duration. Most reformed jurisdictions elsewhere require guardianship orders to include a review date, with the maximum period varying.[29] Many personal orders will have to be limited in time because of the general provisions as to benefit and least restrictive intervention. It is important that orders appointing managers have a maximum life, even if in some cases the scope for circumstances to change is limited.

6.23 Orders and appointments can be limited in time by providing either that they lapse at a certain time or that they must be reviewed. We have suggested that the appointment of a financial manager should be limited to six or twelve months at a time.[30] It may be that maximum life of a personal order could be rather longer, given the range of alternative ways of providing for financial management and the types of long term incapacity for which

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[29] For example, 3 years in Victoria and New Zealand, 6 years in Alberta.

[30] See para.5.27 above.

personal appointments might be appropriate.[31] We invite comments on this. In the interests of consistency between financial and personal management, we provisionally propose that:

11. The maximum duration of any personal order or management appointment in the first instance should be [six or] twelve months. Appointments should be renewable for [six or] twelve months at a time.

6.24 Supervision of continuing managers can be effected by a requirement that they file a regular report. However, this might simply burden many conscientious managers without achieving any significant protection of the incapacitated person. We do not propose that there be any filing requirement.

6.25 Unlike its counterpart in Scotland, the English Mental Health Act Commission has no powers to visit or handle complaints from persons placed under Mental Health Act guardianship.[32] Such powers can have a powerful protective effect. We therefore invite views upon whether there should be such a body in relation to these clients and if so whether the supervisory role of the Mental Health Act Commission might be extended to them:

12. The powers of the Mental Health Act Commission should be extended to persons for whom a personal manager has been appointed.

Duties and liabilities of managers

6.26 We have proposed that a carer who chooses to care for an incapacitated person be under a duty to exercise authority in that person's best interests. It seems reasonable to impose a slightly greater duty on a manager appointed by a judicial body after a procedure of some formality. We would propose that such a manager be under a positive duty to take

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[31] Recent Scottish cases have seen appointments of tutors-dative for periods of five and ten years (A. Ward, *op.cit.*, at p.327). The Scottish Law Commission proposed a maximum life of five years for an order appointing a personal guardian (Discussion Paper No. 94, para. 2.95).

[32] At present, its powers are limited to patients liable to compulsory detention in hospital, although its powers may be extended to informal hospital patients by direction of the Secretary of State: Mental Health Act 1983, s.121(4).

action in the incapacitated person's best interests. Thus, there would be liability for omissions. We therefore invite views on whether:

13. A personal manager must act in the best interests of the incapacitated person, taking into account:

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

6.27 We also propose that the presumption of competence should continue to apply, even where a manager has been appointed. Any manager will be under a continuing obligation to allow the person concerned to take any decisions they acquire or regain the capacity to make.

6.28 The concept of partial and fluctuating capacity may cause complications for third parties. This is likely to be less of an issue in the personal care field than in relation to financial transactions or decisions about medical treatment. Our general proposal is that, in spite of the existence of a management order, a person may have capacity to act on his or her own behalf and not through the manager. There is therefore no need to interfere with the general law as to the contractual and tortious liability of incapacitated persons.

6.29 We do not envisage a management order raising any question of liability in tort of the manager to third parties, since we favour a series of authorisations rather than the granting of full "custodial" powers over the incapacitated person.

6.30 We invite views on whether there should be any specific criminal liability on personal managers. If they have care of the incapacitated adult the criminal liability for ill-treatment and wilful neglect by a carer will apply to them.[33] We doubt the need for further provision.

Remuneration

6.31 Other jurisdictions do not permit personal guardians to be paid fees, but most of them allow guardians to be reimbursed their expenses from the estate (if any) of the incapacitated person. If a Director of Social Services is appointed, it may be appropriate for the usual discretionary charging provisions to apply.[34] Many authorities might choose not to make a charge for this service, and many clients would not have the funds to pay, but there could be some with substantial funds who could afford to do so. We therefore invite views on the following:

14. A private personal manager should be able to recover the expenses of acting. If a Director of Social Services is appointed, the usual discretionary charging provisions should apply.

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[33] See above, para. 2.22.

[34] As in Health and Social Services and Social Security Adjudications Act 1983, s.17.

PART VII

ENDURING POWERS OF ATTORNEY

Introduction

7.1 Since the coming into force[1] of the Enduring Powers of Attorney Act 1985, it has been open to those with capacity to execute an enduring power of attorney (hereafter EPA) to arrange for the conduct of their financial and business affairs even if they should later lose capacity. Our consultation paper canvassed the possibility of extending this scheme to cover personal care decisions,[2] and many of our respondents supported this suggestion. It was said to be of relevance not only to the ageing who anticipate loss of capacity but also to those with recurrent mental illness. Further, since it had been established[3] that capacity to make an appointment can exist even where capacity to make the decisions delegated does not, people with learning disabilities could make valid appointments which would benefit them. The consultation paper also suggested that improvements in the existing scheme for EPAs might be possible, either by increasing the procedural safeguards which exist or by abandoning them.[4] Many of our respondents expressed support for the concept of an EPA, but dissatisfaction with the present procedural requirements.

Extending the scope of enduring powers of attorney

7.2 There may be no objection in principle to the law enabling people to choose a substitute decision-maker for any decisions they wish, especially since this is already permitted in relation to financial matters. Nonetheless, decisions about personal care and welfare have intimate and ethical dimensions which might not arise with financial decisions.[5]

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1 On 10 March 1986.

2 Consultation Paper No. 119, para. 6.14.

3 *Re K., Re F.* [1988] Ch. 310.

4 Consultation Paper No. 119, para. 6.16.

5 Powers of attorney in relation to health care decisions will be dealt with separately.

The list of "personal decisions" set out in paragraph 6.1 reveals the delicate nature of some of the matters under discussion. It can be argued that matters such as "whom to see" are simply not capable of delegation, not least because people can change their views on them on a daily basis. We intend to consider advance directives and the appointment of proxies for health care separately. It is noteworthy that Victoria recently extended the scope of its EPA scheme to include medical treatment decisions only.[6]

7.3 There is, however, a clear demand for legislation to govern advance appointment of personal decision-makers, and this has already been achieved in many jurisdictions. There is no doubt that situations arise where "personal" decisions do have to be taken on behalf of a person who has no capacity to take them. Decisions about residence and health care are the prime examples. If procedures for substitute decision-making in a legal forum are to be constructed, then it must follow that people who wish to make advance provision for the same difficulties should be permitted to do so. This is consonant with the aim of enabling and empowering people to make their own decisions and the principle of "least restrictive intervention." We therefore propose that:

1. **It should be possible for a person to execute an enduring power of attorney giving another person the right to make some or all decisions about the donor's personal care and welfare.**

Procedures and safeguards

7.4 If personal welfare EPAs are to be introduced, we see a vital role for the law in establishing safeguards to protect the donor from abuse of the power by the attorney. The difficulty of balancing the desirability of "simplicity" of procedure with the necessity of "safeguards" for the donor was fully explored in the Commission's report which preceded the Enduring Powers of Attorney Act 1985.[7] The existing provisions of the 1985 Act have now been in operation for some time and research commissioned by the Lord Chancellor's

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[6] See the Medical Treatment (Enduring Powers of Attorney) Act 1990.

[7] The Incapacitated Principal (1983), Law Com. No. 122.

Department[8] has pointed to some difficulties and dissatisfactions, in particular with the operation of the present requirement for registration at the onset of incapacity. We make suggestions for reform of the existing scheme at the same time as exploring its extension to personal care matters.

The effect of incapacity

7.5 At present, an EPA (like an ordinary power of attorney) is effective as from the date of execution unless the donor makes it contingent on the occurrence of some future event. The donor must have capacity to execute the document, such capacity being defined by the common law rather than statute.[9] Donors do not lose their own powers by delegating them, and there have always been good reasons for mentally capable persons delegating the conduct of their financial affairs to others; donors might be out of the country when transactions have to be completed, or physically incapable of getting to the bank or signing their names. Donors can always revoke ordinary powers of attorney, whether expressly or simply by doing an act incompatible with the continued operation of the power.

7.6 The basic concept of co-existent authority to act as between donor and attorney was modified by the Enduring Powers of Attorney Act 1985. An attorney under an enduring power of attorney is under a duty to notify relatives and then apply to the Court of Protection for registration of the power if "he has reason to believe the donor is or is becoming mentally incapable."[10] "Mentally incapable" is defined in the statute.[11] Registration of an EPA in

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8 S. Cretney, G. Davis, R. Kerridge, A. Borkowski, *Enduring Powers of Attorney : A Report to the Lord Chancellor*, (1991).

9 *Re K, Re F* [1988] Ch. 310 is the leading case. The test of capacity to execute a valid EPA adopted has four elements. In summary, the donor must understand:

(1) He is granting complete authority.
(2) The attorney will be able to do anything he could have done.
(3) The power will continue when the donor is incapable.
(4) The power cannot be revoked without the Court's approval once the donor loses capacity.

10 Enduring Powers of Attorney Act 1985, s.4 (1).

11 "...incapable by reason of mental disorder of managing and administering his property and affairs." Enduring Powers of Attorney Act 1985, s.13(1). The definition mirrors that in the Mental Health Act 1983, s.94(2), governing the jurisdiction of the Court of Protection.

accordance with the Act deprives the donor of his or her power to "extend or restrict the scope of the authority."[12] Nor may the donor revoke the power without the confirmation of the Court of Protection.[13]

7.7 Once the power has been registered it has been said that the 1985 Act "requires it to be assumed that the donor has no capacity even though he may in fact have capacity."[14] However, although the Act does specifically state that an attorney may not rely upon any further authorisations given by the donor it does not state that a donor cannot continue to do those things which he or she still has, or has regained, the capacity to do. The problem in practice will be that any third party who knows about the registration of the power will be reluctant to enter into a transaction which might subsequently be avoided.[15] Hence the present position lacks clarity and fails to take into account the likelihood of partial and fluctuating incapacity which was stressed by many of our respondents.

7.8 Special considerations apply to capacity to make personal care decisions. It can be argued that no "personal care" attorney should be permitted to take a decision while the donor retains the capacity to take that decision personally. This would mean that donors and attorneys could never have co-existent "personal" powers. The donor would have all power until incapacity supervened; at which point the attorney would acquire all power (as a financial attorney does at present). This approach has commended itself to other jurisdictions[16] and was adopted by the Scottish Law Commission in their proposal that "a personal welfare attorney should not have authority to make a decision in respect of a

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[12] Enduring Powers of Attorney Act 1985, s.7 (1) (c).

[13] *Ibid.*, s.7(1)(a).

[14] S. Cretney, *Enduring Powers of Attorney*, (3rd ed. 1991), para. 4.9.3.

[15] A contract entered into by a person under a mental disability is voidable (at his or her option) unless entered into during a lucid interval (*Hall v. Warren* (1804) 9 Ves. 605), but only if the other party knew (*Imperial Loan Co. v. Stone* [1892] 1 Q.B. 599) or ought to have known (see *York Glass Co. v. Jubb* (1925) 134 L.T. 36) of the disability.

[16] See for example Ontario (Substitute Decisions Bill, clause 49) and New Zealand (Protection of Personal and Property Rights Act 1988, s.98(3)).

personal welfare matter while the granter is capable of making an informed decision in that matter."[17]

7.9 However, it can equally be said that capable people who wish to delegate their personal decision-making should be allowed to do so. With regard to financial matters, it appears that donor and attorney may have concurrent power to do those things which the donor remains capable of doing. There is a case for saying that donors should lose all capacity to enter into any transaction once the power is registered or (if the registration requirement disappears, at the onset of general incapacity to manage). This would give certainty to third parties, and the attorney's power to manage the donor's whole estate might otherwise be prejudiced. On the other hand, it seems wrong to prohibit the donor from acting on his or her own behalf when the attorney is under no duty to act. Further, such a rule would only be compatible with the retention and even strengthening of a registration requirement. With regard to personal powers, we take the view that donors must retain capacity to act whenever they do in fact have it. However, there may still be a case for allowing concurrent powers. There is nothing inherently shocking in a tired, ill or lazy person asking someone else to make a decision. If a donor and attorney have co-existent personal powers and disagree then the donor can make this known to any third party involved. A dispute in such circumstances can be referred to a judicial forum. Any stipulation that the attorney has no authority while the donor has capacity would impose a heavy burden of assessment on the attorney. If the stipulation is not backed up by some procedural safeguard then it is anyway meaningless. If it is followed through to its logical conclusion, it means that the attorney has to make an assessment of capacity every time he or she contemplates action on behalf of the donor, and may be tempted to take no action at all.

7.10 It appears unsatisfactory that the existing scheme for financial attorneys imposes incapacity even where there may be none. We acknowledge that the donor's inability to revoke an EPA after registration has advantages for third parties. Nevertheless there are many unregistered powers, both ordinary and enduring, in relation to which both attorneys and third

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[17] Discussion Paper No. 94, para. 5.124.

parties are protected under the Powers of Attorney Act 1971.[18] The question, therefore, is whether it is justifiable to deprive capable people of their power to act, including to revoke an EPA, simply because from time to time or in some respects they may be incapable. Equally, it appears unsatisfactory that a new scheme for personal care attorneyships should rule out delegation by someone who wishes to delegate. We would prefer a scheme giving flexibility in both directions, and better catering for the notion that capacity can be partial, and come and go. Hence our broad provisional proposal is that:

2. A donor under an enduring power of attorney whether for financial or personal matters should always retain the power to do any act, including revoking the EPA, in relation to which he or she has capacity at the time.

7.11 The definition of incapacity should obviously be the same not only for any purpose connected with an EPA but also for the purpose of the rule invalidating an ordinary power. We favour making the definition of incapacity for this purpose the same as that proposed in Part III[19] of this paper. The new definition stresses that capacity is specific to particular decisions and is more detailed than the existing one. Confusion would be caused if two different definitions have to be applied where a person has simultaneously executed a financial and a personal welfare EPA, and another for the revocation rule. We therefore provisionally propose that:

3. The definition of incapacity for any purpose connected with an enduring power of attorney, and for the purpose of invalidating an ordinary power, should be the same as that proposed in Part III.

A standard form

7.12 One way of safeguarding donors of EPAs is by requiring that they use a standard form with explanatory notes. This requirement exists in our present EPA scheme, but it may be

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[18] Section 5.

[19] See para. 3.43.

that full advantage of the protective effect of the requirement is not taken. The Court of Protection has calculated that 98.4% of the EPAs submitted for registration are "general", that is they grant power "in relation to all my property and affairs."[20] It is partly because the standard form EPA is so simple in its terms that the threshold of mental capacity required validly to execute it can be so low. The logical conclusion, surprising as it was to many, is that a valid EPA can be executed (with capacity) on the same day that the registration procedure is embarked upon (on the basis of incapacity).[21]

7.13 If it is feared that the threshold of capacity is now too low, one way of raising it is to make the standard form more complex and demanding. This would give the form itself far greater protective effect. In relation to personal care matters, we do not favour the grant of authority in a bland formula such as "in relation to my personal care and welfare." We invite views on whether a new standard form should list a range of personal welfare powers and require the donor positively to choose which ones to delegate. This in itself might minimise the possibility of unfair pressure by the attorney, and lack of full understanding by the donor. Personal care decisions capable of delegation might comprise:

(1) Where I should live
(2) Whom I should live with
(3) Whom I should see and not see
(4) Which social activities I should be involved in
(5) Whether I should work, where, what as
(6) What education or training I should go on
(7) Day-to-day decisions, including diet and dress
(8) Reading any correspondence addressed to me
(9) Inspecting my personal papers and will
(10) Exercising my personal rights to information
(11) Applying for housing, social services and other benefits for me
(12) Deciding whether I should leave the country[22]

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20 S.Cretney, G.Davis, A.Borkowski, R. Kerridge, *Enduring Powers of Attorney: A Report to the Lord Chancellor* (1991), para. 2.14.

21 See further *Re K, Re F* [1988] Ch. 310.

22 This list largely repeats the list at para. 6.1 above.

The form could also encourage the donor to give directives to the attorney. These are likely to be most important in relation to medical matters. However, donors may have firm opinions as to particular people that they wish or do not wish to see, or a place they do not want to live.

7.14 It might be argued that the standard document for a financial EPA should similarly be more demanding. The form could require the donor to choose from a list of decisions to be delegated. This might comprise:

(1) To collect any income due to me
(2) To collect any capital due to me
(3) To sell any of my personal possessions
(4) To sell or surrender my home or any of my real property
(5) To spend any of my income
(6) To spend any of my capital
(7) To exercise any of my powers as a trustee

Although the explanatory notes to the existing form do stress that "general power" may include the power to sell a donor's house, we would welcome views on whether the range of powers delegated should be specified in every case. At present, the form advises donors that they can restrict the attorney's powers if they wish to. Statistics[23] would appear to indicate that donors do not generally wish to do so. We invite comments on the following:

4. A donor of an enduring power of attorney [whether] for personal [or financial] matters should specify which decisions the attorney is authorised to make on his or her behalf.

Execution requirements

7.15 At present, both donor and attorney under an EPA must execute in the presence of a witness. The donor certifies that he or she has read the explanatory notes. Other jurisdictions

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[23] See above, para. 7.12.

require certifications from witnesses as to the ability of the donor to act.[24] The Scottish Law Commission tended to the view that a solicitor should certify that he or she has explained the nature and effect of the document to the donor.[25] The research report commissioned by the Lord Chancellor's Department suggested that a system for certification by a medical practitioner of the donor's capacity on execution would be "a more effective safeguard" than the existing notification and registration scheme.[26] It can be argued that the capacity of the donor to execute the document is of much greater significance than supervening incapacity. If the existing notification and registration requirements are felt unnecessary or ineffective, we would propose that a certificate at the time of execution (together with a more complicated standard form) would be one way of replacing them. However, although capacity is a legal rather than a strictly medical concept, it appears that most EPAs are drafted by solicitors acting for the donor;[27] we would therefore prefer to combine the requirements for legal and medical certification of capacity. We therefore suggest that there should be certificates from both the solicitor and from a registered medical practitioner, that each has seen the donor recently, and explained the nature and effect of the document, and that he or she appears to undertand it. We invite comments on this matter and suggest that:

5. The donor's capacity to execute an EPA should be certified by a solicitor and a registered medical practitioner at the time of execution.

Notification of relatives

7.16 Under our present financial EPA scheme, an attorney is under a duty to notify the donor and specified relatives when he or she believes the donor to be or be becoming

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24 For example, Quebec Civil Code Article 1731.2 as amended by the Public Curator Act 1989, section 111; and see Ontario Substitute Decisions Bill, clause 48 (3).

25 Discussion Paper No. 94, para. 5.16.

26 S.Cretney et al, *op. cit.*, para. 2.40.

27 S. Cretney et al, *op. cit.*, suggest that it is not always clear whether the solicitor is acting for the donor or for the attorney and that solicitors do not always see or arrange for the donor to be seen before accepting instructions or procuring execution. In our view, it should be made clear that the solicitor is acting for the donor.

mentally incapable.[28] In the context of the principle of "least restrictive intervention", the requirement of notification is hard to justify. If a person, presumed competent, chooses to appoint a proxy decision-maker we are not sure why the law should require that proxy to notify often distant family members that the person's faculties are failing. A family member with any involvement with the person would find out that the proxy was acting. If there is legitimate concern, they can have access to the court.[29] This appears preferable to the law determining who is to be told that a person is becoming incapable, and literally inviting them to object to the person's choice of proxy. At the same time, we are mindful of the principle of protection and the public interest in ensuring that proxy decision-making, especially in relation to personal welfare, with all its ethical complexities, be properly regulated.

7.17 If safeguards for the donor are to be shifted from the point of incapacity to the point of executing the document, it can be argued that any notification should take place then. A standard form could ask the donor to state the names and addresses of two persons who are to be sent copies of the document, together with an explanation of its nature and effect and why they are being notified of it. The attorney might then be prohibited from acting until an acknowledgement was received from each of them. If no acknowledgement is received, directions would have to be sought from the court or other judicial authority.

7.18 Alternatively, if registration is to continue, we would propose that the standard form ask the donor to state who should be notified of the attorney's belief that the donor is or is becoming incapable of decision-making. Again, the names and addresses of a minimum of two persons should be required. We therefore provisionally propose:

6. A donor should name in an EPA the two (or more) persons who are to be notified of its execution and no action should be taken by an attorney under the power unless and until an acknowledgement has been received from the persons so named.

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[28] Enduring Powers of Attorney Act 1985, Schedule 1, para. 1.

[29] See below, para. 7.35 *et seq.*.

Assessment by prior appointees

7.19 At present a donor may specify that an EPA is to have no effect until the donor's incapacity (a "springing" power of attorney) although it appears that this is rarely done. A number of jurisdictions which require an assessment of capacity as a precondition to validation or registration of an EPA allow donors to choose in the EPA who should assess their capacity. This has the merit of enabling a donor to choose a trusted assessor but we doubt that it would protect a suggestible donor who is being put under pressure by a prospective attorney. Such a provision is based on the notion that incapacity arises at a particular moment and concentrates on attempting to identify that moment in the least restrictive way possible. It might, however, have some merit where the principal safeguards operate at the point of execution and the donor wishes to add a condition that the power is not to operate until the onset of incapacity or any other objectively ascertainable condition. We envisage that although the choice of assessor is necessarily subjective the incapacity (or other ground for triggering the power) should be established on the basis of objective criteria. We therefore provisionally propose that:

7. Where an EPA is only to take effect at the onset of incapacity, the donor should be permitted to name persons to assess his or her capacity.

Registration

7.20 At present, an attorney under an EPA is under a duty to apply for registration of the power when he or she believes mental incapacity is commencing in the donor. The Commission saw the registration requirement as a necessary adjunct to the safeguarding mechanism of notifying relatives, as well as a confirmation of authority for the attorney and third parties.[30] Registration is linked, not to the effectiveness of the power, but to the existence of incapacity. We have pointed out the unsatisfactory result that incapacity in the donor is presumed (at least for certain purposes) after registration. This is in spite of the fact that no independent medical evidence is usually sought by the court. Many of our respondents

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[30] Law Com. No. 122, para. 4.34.

argued that the registration requirement burdened the conscientious, who would be conscientious without it. Since it need not be linked to the power becoming effective it is easy to ignore by the dishonest, who can simply continue to use a document which has been perfectly valid while the donor has had capacity. Thus no effective protection is achieved. The Scottish Law Commission has tentatively rejected any registration requirement, preferring to rely on the grant of powers to the court to intervene in case of dispute of difficulty.[31] This is the approach adopted in New Zealand.[32]

7.21 By contrast, a very complex registration scheme proposed in Ontario seeks to link registration both to the actual effectiveness of the EPA and to the concept of partial incapacity. It is proposed that no personal care EPA be effective until validated by the Public Guardian and Trustee (hereafter PGT) or the court. The PGT cannot validate without a report from an advocate who has visited and explained matters to the donor, *and* two assessments of the donor's incapacity. The validation of the PGT can only apply to those specific functions of which the assessors have found the donor incapable.[33] If incapacity in relation to other functions arises, a further validation application will presumably be required.

7.22 The complexities of the Ontario scheme illustrate the difficulties of rendering registration compatible with the notion of partial and fluctuating capacity. The existing scheme in England and Wales is premised on there being an absolute coincidence between incapacity and registration, with the unsatisfactory result that incapacity in the donor may be presumed after registration. If, as we have suggested, the vital starting-point is the principle that the donor be allowed to exercise any legal capacity he or she has then our existing registration scheme must be called into question. There are two ways of fitting this starting-point into a system of registration: (1) registration which records actual incapacity on the part of the donor - leading to limited and repeated registrations; or (2) registration which has no effect on the authority of the donor to continue exercising such capacity as he or she has. The former leads to great procedural complexity, and the latter may be thought a waste of

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[31] Discussion Paper no. 94, para. 5.50.

[32] Protection of Personal and Property Rights Act 1988, Part IX.

[33] Substitute Decisions Bill, clause 49.

time. A third option is to abandon registration as an effective protective mechanism and concentrate on safeguards which ensure that the donor has full and proper appreciation of what he or she is doing when the EPA is first executed.

7.23 One possible advantage of the registration scheme is that prior notice of an intention to register must normally be personally delivered to the donor. This may safeguard a capable donor against an attorney who seeks to presume his or her incapacity. However, notification can be dispensed with where the attorney alleges that this would be undesirable or impracticable, or likely to serve no useful purpose.[34] Furthermore it is unusual for EPAs to be conditional on incapacity so that an unscrupulous attorney may take advantage in any event. It is also not the practice of the Court to insist on independent evidence of incapacity at registration. Therefore we tend to agree with the authors of the research report to the Lord Chancellor that "there is no clear indication of what registration is designed to achieve."[35] We tend to think protective mechanisms could more sensibly apply to the moment of creation.[36] The Court should continue to have power to remove unsuitable attorneys, but as part of our proposed new jurisdiction in relation to incapacitated people, rather than as part of a registration scheme. We therefore invite comments on the proposal that:

8. There should no longer be a requirement that an EPA be registered with the Court of Protection when the attorney believes the donor to be or be becoming incapable.

Prohibited attorneys

7.24 While, at present in England and Wales, a financial attorney can be either an individual or a trust corporation, it seems preferable that a personal care attorney must be an individual. We provisionally propose that:

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[34] Enduring Powers of Attorney Act 1985, Schedule 1, paras. 3(2) and 4(2).

[35] S. Cretney et al, *op. cit.*, para. 2.36.

[36] See above, paras 7.15 - 7.19 and proposals 5, 6 and 7.

9. Only individuals should be capable of being appointed "personal care" attorneys.

7.25 Some jurisdictions disallow joint attorneys in the personal care field, presumably on the basis that scope for disagreement should be minimised.[37] We are not convinced by any argument against joint attorneys, and think that this may be another valuable safeguard. If two people disagree about the best interests of the person, that seems a good pointer to the need for the involvement of a judicial body.[38] It should be open to the donor to decide whether the authority of joint attorneys should be joint and several. At present, no power of attorney which allows an attorney to appoint a substitute or successor can be an EPA.[39] Furthermore, if more than one attorney is appointed they must be either "joint" or "joint and several."[40] Although this may not rule out the inclusion of an "alternate" attorney where the first attorney never starts to act, it does rule out the inclusion of a substitute to take over where an acting attorney dies or cannot carry on acting. We take the view that the donor should be able to provide for an alternative attorney if a first attorney (perhaps a contemporary, particularly a spouse) becomes unable to continue acting. We therefore propose that:

10. It should be possible for more than one person to be appointed as personal care attorneys, whether to act jointly or jointly and severally. It should also be possible for alternate attorneys to be appointed to act in the event of original attorneys ceasing to act.

7.26 It is proposed in Ontario that the Public Guardian and Trustee can, with consent, be appointed an attorney for both financial matters and personal care. This is certainly consistent with "enabling and empowering" as many people as possible to make their own decisions in advance, and allows those with no candidate of their own to make provision for their future care. It might avoid complex court procedures if decisions did have to be made about persons

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[37] New Zealand Protection of Personal and Property Rights Act 1988, s.98 (2).

[38] See below, para. 7.35.

[39] Enduring Powers of Attorney Act 1985, s.2(9).

[40] *Ibid.*, s11 (1).

or property after the onset of incapacity. In England and Wales, public officials in local authorities, the Public Trust Office[41] or the Official Solicitor's Department might be candidates. Of these, a local authority social worker or the Director of Social Services might be thought the most appropriate.

7.27 However, a power of attorney is in essence an agency arrangement whereby authority is delegated by an individual to a chosen and trusted associate. Although there may be a case for a public official to act as a personal manager of last resort,[42] we consider that it would be wrong in principle for any public official, particularly a service-provider, to be appointed a personal care attorney. For example, if a social worker or Director of Social Services were appointed, he or she might find that there was an irreconcilable conflict between the ascertainable wishes of the donor and the policy and practice of the local authority concerned. We therefore provisionally propose that:

11. It should not be possible to appoint public officials in their official capacity as attorneys.

Prohibited powers

7.28 The Enduring Powers of Attorney Act 1985 states that a general authority in an EPA confers "authority to do on behalf of the donor anything which the donor can lawfully do by an attorney."[43] Actions which require personal steps by the donor (such as executing a will) are thereby excluded.[44] If personal care EPAs are to be introduced a matching provision would exclude the matters mentioned in Part VI as incapable of delegation.[45]

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41 The Public Trustee can act as a Receiver under Part VII of the Mental Health Act 1983, if no other candidate is available.

42 See para. 6.19 above.

43 s. 3 (2). Subsections (4) and (5) give further guidance about benefits to persons other than the donor and gifts.

44 See further S. Cretney, *op. cit.*, para. 4.5.1.

45 Namely, decisions about marriage, consent to divorce, sexual relations, adoption, voting, jury service and wills. See above, para. 6.3.

7.29 There may be an argument for stating in terms whether and which "personal powers" cannot be delegated to an attorney.[46] Donors and attorneys may be unsure of the general law. Many American states disallow proxy consent to admission to any mental health facility[47] and we will be considering separately the whole topic of advance directives in relation to medical matters. Subject to that, it may be that our proposal that specific powers must be granted in the document will diminish the possibility of disputes about whether certain matters are capable of delegation, and that no specific personal powers need therefore be excluded from possible delegation. However, we invite comments on this matter.

Duties and liabilities of attorneys

7.30 No attorney is under a legal duty to act.[48] If an attorney does act then he or she must do so within the scope of the power granted and in accordance with a duty of care to the donor. The standard of care will be that of a person managing his or her own affairs, except that where the attorney is a "professional" attorney then normal professional competence must be shown.[49] Thus, an attorney may be liable in negligence for breach of that duty of care. Although additional statutory duties are imposed by the 1985 Act, no specific provision as to liability for breach is made. The 1985 Act does impose criminal liability for the making of a false statement by an attorney in a registration application.[50]

7.31 Especially if powers of attorney are to be extended to personal care matters, we take the view that an attorney should be under the same duty to act in the best interests of the donor that we proposed for carers and managers.[51] This gives specific guidance as to the

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[46] The Ontario Substitute Decisions Bill (clause 47(7)) provides that an attorney cannot be authorised to consent to non-therapeutic sterilisation or psychosurgery. In the New Zealand Protection of Personal and Property Rights Act 1988, decision-making powers about marriage, divorce, adoption, and certain medical matters are denied to attorneys (s.98(4)).

[47] California's Durable Power of Attorney for Health Care Act 1983 is an example.

[48] See Law Com. No. 122, paras. 4.67-69 for the argument against imposing such a duty.

[49] Law Com. No. 122, paras. 2.13 - 2.14.

[50] Enduring Powers of Attorney Act 1985, s. 4(7).

[51] See above, paras. 2.15 and 6.26.

matters which the attorney must bear in mind. We would like to see this guidance extended to attorneys with financial powers and therefore propose that:

12. An attorney should be under no duty to act on behalf of the donor. If an attorney acts on behalf of a donor he or she must act in the best interests of the donor, taking into account:

(1) the ascertainable past and present wishes and feelings of the donor;

(2) the need to encourage and permit the donor to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the donor's freedom of decision and action is likely to be in his or her best interests.

The attorney in relation to carers and managers

7.32 An attorney may not be the same person as the carer. The carer will have to consult with an attorney because the execution of the power of attorney will be an indication of the wishes and feelings of the incapacitated person, and one of the matters which the carer must take into account. We do not think any more specific provision about the inter-relationship of carer and attorney need be made.

7.33 We expect that in many cases the same person will be appointed to act as financial and personal care attorney. However, there could be two separate documents governing the two appointments and it would be open to a donor to appoint separate attorneys. It may sometimes be desirable that the financial attorney have professional skills in managing money or property. The personal care attorney is perhaps likely to have been closer to the donor and more attuned to what he or she would have wanted. Where there are two attorneys, they should have a duty to consult one another, and in cases of dispute over a matter over which they both have power, the decision of a personal care attorney should take precedence. We therefore provisionally propose that:

13. **Where separate attorneys are appointed for financial and personal care matters they should have a duty, so far as practicable, to consult with one another. Should their powers overlap in any respect, the decision of the personal care attorney should prevail.**

7.34 The authority of any manager will have been granted by the court and will, in principle, override that of any attorney. Again, the court will have been obliged to consider the existence and terms of any power of attorney (as an indication of the donor's wishes and feelings) before making any order or appointing any manager. This brings us to consider the powers of the court in relation to powers of attorney.

The powers of the judicial authority

7.35 It is consistent with our policy that intervention should always be as limited as possible that maximum possible effect be given to a duly executed power of attorney. If resort has to be had to the judicial authority because of a dispute or difficulty concerning the person or property of an incapacitated person, a different starting-point should be adopted where a power of attorney is in existence. Under the 1985 Act the Court of Protection can determine questions about the meaning or effect of an EPA, and give directions and authorisations to attorneys.[52] Such powers should be available to the judicial authority in relation to personal welfare EPAs, and could be further extended, to the point where the court could modify or extend the scope of the document itself.

7.36 In particular, we favour the court having power to replace one attorney with another where the attorney appointed is unable to act. There should also be extended powers to cure defects in the document, so that where the donor's clear intention was to appoint an attorney under an EPA, this can be implemented. The Bristol research indicated that many EPAs could not be registered because of technical defects, with the result that a Receiver had to be

[52] Enduring Powers of Attorney Act 1985, s.8.

appointed.[53] If such powers existed, there would be little need for EPAs to be revoked by the court and replaced with management orders.

7.37 We have considered whether the judicial authority should be able to extend the scope of an EPA which only covers financial and business matters into the personal care field. It can be argued that a donor who has declined to execute a personal care EPA is in the same position as regards personal decisions as a person who has executed no EPA at all. The judicial authority could always make an order or appoint a manager as appropriate. However, we have suggested that the execution of an EPA creates a different starting point for the judicial authority, in that the donor has already indicated that he or she wishes a certain person to act in the event of incapacity, and that he or she wishes certain decisions to be taken. Just as the donor may be content for the court to appoint a different attorney should the person chosen be unable to act, the donor may be content for the court to extend or modify the attorney's powers should the need arise. The advantage would be that the attorney would not have to return to court at regular intervals. It would, of course, be open to the court to decline to extend an attorney's powers if an alternative order were more appropriate. The standard form might, therefore, invite the donor to indicate whether or not he or she consents to the court having power to extend the powers of the attorney after the donor becomes incapacitated. We therefore invite views on the following proposal:

14. The judicial authority should have power to give effect to the wishes of the donor by curing technical defects in the execution of an EPA, or by appointing a replacement for an attorney who is unable to act, and, provided that the donor has so directed, by modifying or extending the scope of the powers granted.

Supervision and review of EPAs

7.38 Under the present scheme, the Court of Protection has wide powers to supervise attorneys, in particular by requiring the attorney to produce accounts or "furnish information

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[53] S. Cretney et al, *op. cit.*, para. 2.16.

or produce documents or things in his possession as attorney."[54] There are, however, no general obligations on attorneys to report to the Court and a lack of enforced oversight is "fundamental to EPAs",[55] which are intended to operate without constant judicial control. If the registration scheme is to be abandoned then any supervisory powers of the court could only relate to EPAs which had come to its attention because of a dispute or difficulty. There may still be cases where the court would wish to call for accounts and reports to be delivered on a regular basis, because of concern for the donor or even the attorney. Equally, if the court has the wide powers described above to modify the scope of an EPA, there may be cases where the court wishes to ensure that additional formal steps are taken by the attorney in relation to certain sorts of decision. The Court of Protection currently deals with many applications from Receivers for additional authority to carry out certain transactions. We do not propose to institute any requirements of regular filing of reports and accounts by all attorneys, as this will often be unnecessary and burdensome. Nor do we see a general need to limit EPAs to a fixed term, after which they would lapse. We prefer to rely, as at present, on powers of the judicial authority to call attorneys to give accounts or reports if an interested party raises a matter of concern. We therefore propose that:

15. The judicial authority should have wide powers to supervise the conduct of attorneys, similar to those of the Court of Protection under the existing legislation.

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[54] Enduring Powers of Attorney Act 1985, s.8(2)(c).

[55] S. Cretney et al., *op. cit.*, para. 2.32.

PART VIII

COLLECTED PROVISIONAL PROPOSALS AND CONSULTATION ISSUES

PART I - INTRODUCTION

We welcome suggestions for alternatives to the term "patient" (paragraph 1.11).

PART II - THE POSITION OF FAMILY AND CARERS

Decision-makers from a statutory list of relatives

1. **There should be no statutory authority to take decisions for an incapacitated person simply on the basis of a family relationship.**

A statutory authority for carers

2. **Anyone who has care of an incapacitated person [or who has reasonable grounds for believing a person in his or her care to be incapacitated] may do what is reasonable in all the circumstances to care for that person and to safeguard and promote his or her personal welfare.**

We invite views on whether a carer should only be required to have reasonable grounds for believing the person being cared for to be incapacitated (paragraph 2.11).

3. **In the exercise of this authority, a carer must act in the best interests of an incapacitated person, taking into account:**

   (1) the ascertainable past and present wishes and feelings of the incapacitated person;

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

4. It is not reasonable for a carer to confine an incapacitated person unless such action is essential to prevent an immediate risk of serious harm to that person or others.

5. It is not reasonable for a carer to force an incapacitated person to act in accordance with a decision to which the incapacitated person objects, unless such action is essential to prevent an immediate risk of serious harm to that person or others.

The carer's liabilities

6. A carer who acts in pursuance of the proposed statutory authority should only be liable if he or she does so in bad faith or without reasonable care.

7. The offence in section 127(2) of the Mental Health Act 1983 should be extended to protect all incapacitated persons from ill-treatment or wilful neglect by their carers.

PART III - DEFINING THE CLIENT GROUP

The relevant age

1. The new jurisdiction should extend to persons aged 16 and over.

The requirement of mental disorder

2. Unless the person concerned falls within a listed exception (see proposal 7 below), it must be established that he or she is suffering from a mental disorder or disability.

3. "Mental disorder" should for this purpose be defined as in section 1(2) of the Mental Health Act 1983 and the exclusions set out in section 1(3) should be retained.

The definition of incapacity

4. A person should be considered unable to take the decision in question (or decisions of the type in question) if he or she is unable to understand an explanation in broad terms and simple language of the basic information relevant to taking it, including information about the reasonably foreseeable consequences of taking or failing to take it, or to retain the information for long enough to take an effective decision.

5. A person should be considered unable to take the decision in question if he or she can understand the information relevant to taking the decision but is unable because of mental disorder to make a true choice in relation to it.

We invite views on whether it need be stipulated that the fact that the person's decision differs from that which an ordinary prudent person would take is not, of itself, a sufficient basis for a finding of incapacity (paragraph 3.25).

Should anyone else be included?

6. **The new jurisdiction should not extend to those who are not legally incapacitated in relation to a particular decision but who request or consent to the making of an order in relation to themselves.**

7. **A person should be considered unable to take the decision in question if he or she is unable to communicate it to others who have made reasonable attempts to understand it.**

Standard of Proof

8. **The standard of proof in relation to findings of legal incapacity should be the standard of proof in civil proceedings.**

Summary

Any new jurisdiction should be available in respect of people of or over the age of 16 who meet either of the following criteria:

(1) **They are (a) suffering from mental disorder within the meaning of the Mental Health Act 1983 and**
(b) either (i) unable to understand an explanation in broad terms and simple language of the basic information relevant to taking the decision in question, including information about the reasonably foreseeable consequences of taking or not taking it, or to retain that information for long enough to take an effective decision or (ii) unable by reason of their mental disorder to make a true choice in relation to that decision.

(2) **They are unable to communicate the decision in question to others who have made reasonable efforts to understand it.**

PART IV - ADMINISTRATIVE AND JUDICIAL DECISION-MAKING

The administrative level

1. **Where a decision is taken by an administrative body on behalf of an incapacitated person, that body should have a duty to act in the best interests of the incapacitated person, taking into account:**

   (1) the ascertainable past and present wishes and feelings of the incapacitated person;

   (2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable; and

   (3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

The judicial level

2. **There should be a new jurisdiction bringing together the judicial functions of the Court of Protection with similar functions in relation to matters of personal care and welfare.**

3. **Having found that a person is incapacitated in relation to the function in question, the judicial authority must be satisfied that the making of an order will bring greater benefit to the incapacitated person than making no order at all.**

4. **The judicial authority should have power both to resolve specific issues and to appoint proxies to manage the incapacitated person's personal care and welfare and/or property and financial affairs.**

5. **An order dealing with a specific issue is to be preferred to the appointment of a manager, unless there is a need for a continuing authority, and any order should be as limited in scope as possible.**

6. **Any order made should be in the best interests of the incapacitated person, taking into account:**

   (1) the ascertainable past and present wishes and feelings of the incapacitated person;

   (2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable;

   (3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

PART V - FINANCIAL DECISION-MAKING

Access to funds held by or on behalf of an incapacitated person

1. **Unless it is established that a claimant is incapacitated, no appointment under the Social Security Regulations should be made without that claimant's consent.**

2. **An appointee should be required in every case to agree to provide, if asked to do so, an account to the authorising Department as to how the claimant's benefits have been spent.**

3. **An appointment should expire after a period of [six or] twelve months unless the Department is satisfied on the basis of a previous appointee's past performance that it would be proper for the appointment to be renewed for a further [six or] twelve month period.**

4. **Institutions such as banks, building societies, and insurance companies, should be able, at their own discretion, to permit a named individual to withdraw money or receive payment from an account or under an insurance policy belonging to an incapacitated person.**

5. **The institution in question should incur no liability for money withdrawn or received provided that:**

   (a) **the client or policyholder had not opted out of the scheme,**

   (b) **an approved "certificate of incapacity" has been lodged, and**

   (c) **the proposed recipient has given an undertaking to use the money in accordance with the statutory duties of a carer.**

6. **If the client or policyholder or any other person notifies the institution in writing that there are reasons why the scheme should not be continued the institution should suspend or terminate all withdrawals or payments pending further investigation or order of the court.**

We welcome comment on the type of institution which might be covered by such a scheme and on the kinds of payments which might be included. We would also

welcome comment on whether there should be a maximum sum (either on a monthly or percentage basis) beyond which no payment should be allowed (paragraph 5.12).

7. Guidance on the duties of institutional appointees might include:

(a) that claimants should receive all benefits to which they are entitled with written reasons given if any entitlement is not being claimed;

(b) that appointees be subjected to spot checks by Department inspectors, especially where that person or body is acting as an appointee for many patients or residents;

(c) that written records, open to inspection, should be kept as to the sums spent and details of how the money is utilised;

(d) that in the case of long-term patients (or long-term nursing or residential home residents), a Review Team should be appointed which would: (i) carry out a regular review of individual patients or residents, their incomes and balances, with a view to encouraging optimal use of funds by staff; (ii) consider hospital cases where it is proposed that allowances should be reduced and review cases where this should be done; and (iii) decide whether the management by the hospital or home of the affairs of individual patients continues to be necessary.

8. Claimants should have a right to complain to an independent tribunal if they cannot gain access to their benefit or feel that it is not being spent on them. Further, if a person is incapable of complaining, a relative or friend should be permitted to do so on his or her behalf.

The authority of a carer or other person to use income or resources on behalf of the incapacitated person

We would welcome comment on whether the carer's authority should exclude all financial decision-making (paragraph 5.20).

9. Where [a carer or] other person is the authorised recipient of payments due to an incapacitated person he or she may do what is reasonable in all the circumstances with regard to those payments.

10. Such a person must act in the best interests of the incapacitated person, taking into account:

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

11. A carer has no authority to enter into contractual relations on behalf of an incapacitated person or to sell or otherwise dispose of that person's property other than with respect to the sale of a chattel where the proceeds do not exceed [£100].

We invite views concerning what the financial limit should be and how it should be calculated (paragraph 5.23).

12. **Where a carer sells or otherwise disposes of a chattel belonging to an incapacitated person he or she must exercise the same duties with respect to that sale or disposal as a carer or other person who receives any other payment due or belonging to that person.**

13. **The Court may grant a general order to a named financial manager to act on behalf of an incapacitated person.**

14. **The order may include authority to: take and grant a lease; sell or purchase property; make repairs or improvements to property belonging to the client; sell furniture and effects; receive all income due to the client; resort to capital for the purpose of maintaining the client; make gifts out of the client's surplus income to reflect the relevant tax exempt limit and make non-monetary gifts to the same value; make investment in or sale from equities or other investment policies on the advice of an investment manager approved by the Court.**

15. **Appointments should be made in the first instance for a period of [six or] twelve months but may be renewed for periods of [six or] twelve months at a time.**

16. **When appointing a financial manager the Court should give consideration to both the level of accounting and security required of that manager and the scope of his or her powers to invest (as well as receive) money due to or belonging to an incapacitated person.**

17. **The financial limit with regard to the jurisdiction of the Court of Protection where no Receiver has been appointed should be removed and the use of single issue orders should be encouraged.**

18. **The Court may direct that a client has capacity to execute an enduring power of attorney within a specified time and may oversee the appointment of a suitable attorney.**

We welcome comment on the benefits of "switching jurisdictions" from managers to attorneys and vice versa (paragraph 5.34).

PART VI - DECISIONS ABOUT PERSONAL CARE AND WELFARE

We welcome views on whether consultation and case conference procedures need be placed on a more formal footing (paragraph 6.6).

A range of orders

1. **The judicial authority may make any one or more of the following personal orders:**

   (i) An order settling the arrangements to be made as to where or with whom an incapacitated person is to live.

   (ii) An order requiring the person with whom the incapacitated person lives to allow that person to visit, stay with or otherwise have contact with another person.

   (iii) An order restraining a person from having contact with, molesting or otherwise interfering with the incapacitated person.

   (iv) An order dealing with a specific issue in relation to the care or welfare of the incapacitated person.

We invite comments on how the scope of such orders should be defined (paragraph 6.12)

2. **If the judicial authority finds that a personal order will not be sufficient to benefit the incapacitated person, it may appoint a continuing personal manager for that person. The manager will have such powers in relation to that person's personal care and welfare as are specified in the order making the appointment.**

3. **Admission to, and detention and treatment in, a hospital or mental nursing home should continue to be governed by the Mental Health Act 1983.**

4. **The judicial authority may declare that the person concerned is not incapacitated, either in general or in relation to a particular matter.**

5. **The judicial authority may make recommendations instead of making any order.**

Applicants

6. **Close relatives, carers and the person himself or herself, should have a right to apply for an order. Other persons might apply with leave of the court.**

7. **Health and social services authorities, and individual professionals, should be permitted to seek leave to apply for any order [apart from a residence order].**

Personal managers

8. **The judicial authority may appoint any person who will discharge the duties of a personal manager and whose interests do not conflict with those of the incapacitated person.**

9. **The judicial authority may appoint the Director of Social Services for the appropriate local authority as personal manager if there is no other suitable candidate.**

10. **The judicial authority may appoint joint, joint and several, alternate or successive personal managers.**

11. **The maximum duration of any personal order or management appointment in the first instance should be [six or] twelve months. Appointments should be renewable for [six or] twelve months at a time.**

We invite comment on the maximum term for an order dealing with personal care and welfare (paragraph 6.23).

12. **The powers of the Mental Health Act Commission should be extended to persons for whom a personal manager has been appointed.**

13. **A personal manager must act in the best interests of the incapacitated person, taking into account:**

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his or her best interests.

We invite views on the need for imposing specific criminal liability on personal managers (paragraph 6.30).

14. **A private personal manager should be able to recover the expenses of acting. If a Director of Social Services is appointed, the usual discretionary charging provisions should apply.**

PART VII - ENDURING POWERS OF ATTORNEY

Extending the scope of enduring powers of attorney

1. **It should be possible for a person to execute an enduring power of attorney giving another person the right to make some or all decisions about the donor's personal care and welfare.**

We invite comments on whether any specific personal powers need be excluded from possible delegation (paragraph 7.29).

Procedures and safeguards

2. **A donor under an enduring power of attorney whether for financial or personal matters should always retain the power to do any act, including revoking the EPA, in relation to which he or she has capacity at the time.**

3. **The definition of incapacity for any purpose connected with an enduring power of attorney, and for the purpose of invalidating an ordinary power, should be the same as that proposed in Part III.**

We invite views on whether a new standard form for an enduring power of attorney should list a range of personal welfare powers and require the donor to choose which to delegate (paragraph 7.13).

4. **A donor of an enduring power of attorney [whether] for personal [or financial] matters should specify which decisions the attorney is authorised to make on his or her behalf.**

5. **The donor's capacity to execute an EPA should be certified by a solicitor and a registered medical practitioner at the time of execution.**

6. **A donor should name in an EPA the two (or more) persons who are to be notified of its execution and no action should be taken by an attorney under the power unless and until an acknowledgement has been received from the persons so named.**

7. **Where an EPA is only to take effect at the onset of incapacity, the donor should be permitted to name persons to assess his or her capacity.**

8. **There should no longer be a requirement that an EPA be registered with the Court of Protection when the attorney believes the donor to be or be becoming incapable.**

9. **Only individuals should be capable of being appointed "personal care" attorneys.**

10. **It should be possible for more than one person to be appointed as personal care attorneys, whether to act jointly or jointly and severally. It should also be possible for alternate attorneys to be appointed to act in the event of original attorneys ceasing to act.**

11. **It should not be possible to appoint public officials in their official capacity as attorneys.**

Duties and liabilities of attorneys

12. An attorney should be under no duty to act on behalf of the donor. If an attorney acts on behalf of a donor he or she must act in the best interests of the donor, taking into account:

(1) the ascertainable past and present wishes and feelings of the donor;

(2) the need to encourage and permit the donor to participate in any decision-making to the fullest extent of which he or she is capable; and

(3) the general principle that the course least restrictive of the donor's freedom of decision and action is likely to be in his or her best interests.

13. Where separate attorneys are appointed for financial and personal care matters they should have a duty, so far as practicable, to consult with one another. Should their powers overlap in any respect, the decision of the personal care attorney should prevail.

The powers of the judicial authority

14. The judicial authority should have power to give effect to the wishes of the donor by curing technical defects in the execution of an EPA, or by appointing a replacement for an attorney who is unable to act, and, provided that the donor has so directed, by modifying or extending the scope of the powers granted.

15. The judicial authority should have wide powers to supervise the conduct of attorneys, similar to those of the Court of Protection under the existing legislation.

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